

AMENDED IN ASSEMBLY MAY 2, 2013

AMENDED IN ASSEMBLY APRIL 16, 2013

AMENDED IN ASSEMBLY MARCH 21, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

## ASSEMBLY BILL

**No. 1180**

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**Introduced by Assembly Member Pan**

February 22, 2013

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An act to amend Sections *1363.06, 1363.07, 1366.3, 1366.35, 1373.6, 1373.621* ~~and~~, *1389.5, 1399.805, 1399.810, 1399.811, and 1399.815* of, ~~to add and repeal Section 1363.08 of, to repeal Section 1399.816 of, and to repeal, add, and repeal Section 1399.818 of, and to add Section 1373.620 to,~~ the Health and Safety Code, and to amend Sections *10116.5, 10119.1, 10127.14, 10127.18,* ~~and~~ *10785, 10901.3, 10901.8, 10901.9, 10902.3, 12672, and 12682.1* of, *to add Section 12682.2 to,* ~~and to repeal Section 10902.4 of, and to repeal, add, and repeal Section 10902.6 of,~~ the Insurance Code, relating to health care coverage, *and declaring the urgency thereof, to take effect immediately.*

### LEGISLATIVE COUNSEL'S DIGEST

AB 1180, as amended, Pan. Health care coverage: federally eligible defined individuals: conversion or continuation of coverage.

(1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Insurance Commissioner. Existing law requires a health care service plan or a health insurer offering individual plan contracts or individual insurance policies to fairly and affirmatively

offer, market, and sell certain individual contracts and policies to all federally eligible defined individuals, as defined, in each service area in which the plan or insurer provides or arranges for the provision of health care services. Existing law prohibits the premium for those policies and contracts from exceeding the premium paid by a subscriber of the California Major Risk Medical Insurance Program who is of the same age and resides in the same geographic region as the federally eligible defined individual, as specified.

This bill would make these provisions of law applicable only to ~~grandfathered individual grandfathered health plan contracts or insurance policies, plans~~, as defined, previously issued to federally eligible defined individuals, unless and until specified provisions of the federal Patient Protection and Affordable Care Act (PPACA) are amended or repealed, as specified. *The bill would also require a health care service plan or an insurer, at least 60 days prior to the plan or policy renewal date, to issue prescribed notifications to a person who is enrolled in an individual health benefit plan or individual health insurance policy that is not a grandfathered health plan. Because a willful violation of this requirement by a health care service plan would be a crime, the bill would impose a state-mandated local program.*

(2) Existing law requires a health care service plan or health insurer to offer continuation or conversion of individual or group coverage for a specified period of time and under certain circumstances.

The bill would make those provisions inoperative, unless and until specified provisions of PPACA are amended or repealed, as specified, and would make conforming changes.

(3) *The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.*

*This bill would provide that no reimbursement is required by this act for a specified reason.*

*This bill would declare that it is to take effect immediately as an urgency statute.*

Vote: ~~majority~~<sup>2/3</sup>. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: ~~no~~ yes.

*The people of the State of California do enact as follows:*

1 ~~SECTION 1. Section 1363.08 is added to the Health and Safety~~  
2 ~~Code, to read:~~

3 ~~1363.08. (a) Sections 1363.06 and 1363.07 shall be inoperative~~  
4 ~~on January 1, 2014.~~

5 ~~(b) If Section 5000A of the Internal Revenue Code, as added~~  
6 ~~by Section 1501 of PPACA, is repealed or amended to no longer~~  
7 ~~apply to the individual market, as defined in Section 2791 of the~~  
8 ~~federal Public Health Service Act (42 U.S.C. Sec. 300gg-04), this~~  
9 ~~section shall become inoperative and shall be repealed on January~~  
10 ~~1 following the date that it becomes inoperative.~~

11 ~~(c) For purposes of this section, "PPACA" means the federal~~  
12 ~~Patient Protection and Affordable Care Act (Public Law 111-148),~~  
13 ~~as amended by the federal Health Care and Education~~  
14 ~~Reconciliation Act of 2010 (Public Law 111-152), and any rules,~~  
15 ~~regulations, or guidance issued pursuant to that law.~~

16 *SECTION 1. Section 1363.06 of the Health and Safety Code*  
17 *is amended to read:*

18 1363.06. (a) The Department of Managed Health Care and the  
19 Department of Insurance shall compile information as required by  
20 this section and Section 10127.14 of the Insurance Code into two  
21 comparative benefit matrices. The first matrix shall compare benefit  
22 packages offered pursuant to Section 1373.62 and Section 10127.15  
23 of the Insurance Code. The second matrix shall compare benefit  
24 packages offered pursuant to Sections 1366.35, 1373.6, and  
25 1399.804 and Sections 10785, 10901.2, and 12682.1 of the  
26 Insurance Code.

27 (b) The comparative benefit matrix shall include:

28 (1) Benefit information submitted by health care service plans  
29 pursuant to subdivision (d) and by health insurers pursuant to  
30 Section 10127.14 of the Insurance Code.

31 (2) The following statements in at least 12-point type at the top  
32 of the matrix:

33 (A) "This benefit summary is intended to help you compare  
34 coverage and benefits and is a summary only. For a more detailed  
35 description of coverage, benefits, and limitations, please contact  
36 the health care service plan or health insurer."

37 (B) "The comparative benefit summary is updated annually, or  
38 more often if necessary to be accurate."

39 (C) "The most current version of this comparative benefit  
40 summary is available on (address of the plan's or insurer's site)."

1 This subparagraph applies only to those plans or insurers that  
2 maintain an Internet Web site.

3 (3) The telephone number or numbers that may be used by an  
4 applicant to contact either the department or the Department of  
5 Insurance, as appropriate, for further assistance.

6 (c) The Department of Managed Health Care and the Department  
7 of Insurance shall jointly prepare two standardized templates for  
8 use by health care service plans and health insurers in submitting  
9 the information required pursuant to subdivision (d) and  
10 subdivision (d) of Section 10127.14 of the Insurance Code. The  
11 templates shall be exempt from the provisions of Chapter 3.5  
12 (commencing with Section 11340) of Part 1 of Division 3 of Title  
13 2 of the Government Code.

14 (d) Health care service plans, except specialized health care  
15 service plans, shall submit the following to the department by  
16 January 31, 2003, and annually thereafter:

17 (1) A summary explanation of the following for each product  
18 described in subdivision (a).

19 (A) Eligibility requirements.

20 (B) The full premium cost of each benefit package in the service  
21 area in which the individual and eligible dependents work or reside.

22 (C) When and under what circumstances benefits cease.

23 (D) The terms under which coverage may be renewed.

24 (E) Other coverage that may be available if benefits under the  
25 described benefit package cease.

26 (F) The circumstances under which choice in the selection of  
27 physicians and providers is permitted.

28 (G) Lifetime and annual maximums.

29 (H) Deductibles.

30 (2) A summary explanation of coverage for the following,  
31 together with the corresponding copayments and limitations, for  
32 each product described in subdivision (a):

33 (A) Professional services.

34 (B) Outpatient services.

35 (C) Hospitalization services.

36 (D) Emergency health coverage.

37 (E) Ambulance services.

38 (F) Prescription drug coverage.

39 (G) Durable medical equipment.

40 (H) Mental health services.

1 (I) Residential treatment.

2 (J) Chemical dependency services.

3 (K) Home health services.

4 (L) Custodial care and skilled nursing facilities.

5 (3) The telephone number or numbers that may be used by an  
6 applicant to access a health care service plan customer service  
7 representative and to request additional information about the plan  
8 contract.

9 (4) Any other information specified by the department in the  
10 template.

11 (e) Each health care service plan shall provide the department  
12 with updates to the information required by subdivision (d) at least  
13 annually, or more often if necessary to maintain the accuracy of  
14 the information.

15 (f) The department and the Department of Insurance shall make  
16 the comparative benefit matrices available on their respective  
17 Internet Web sites and to the health care service plans and health  
18 insurers for dissemination as required by Section 1373.6 and  
19 Section 12682.1 of the Insurance Code, after confirming the  
20 accuracy of the description of the matrices with the health care  
21 service plans and health insurers.

22 (g) As used in this section and Section 1363.07, “benefit matrix”  
23 shall have the same meaning as benefit summary.

24 (h) (1) *This section shall be inoperative on January 1, 2014.*

25 (2) *If Section 5000A of the Internal Revenue Code, as added by*  
26 *Section 1501 of PPACA, is repealed or amended to no longer apply*  
27 *to the individual market, as defined in Section 2791 of the federal*  
28 *Public Health Service Act (42 U.S.C. Sec. 300gg-91), this section*  
29 *shall become operative on the date of that repeal or amendment.*

30 (3) *For purposes of this subdivision, “PPACA” means the*  
31 *federal Patient Protection and Affordable Care Act (Public Law*  
32 *111-148), as amended by the federal Health Care Education and*  
33 *Reconciliation Act of 2010 (Public Law 111-152), and any rules,*  
34 *regulations, or guidance issued pursuant to that law.*

35 SEC. 2. *Section 1363.07 of the Health and Safety Code is*  
36 *amended to read:*

37 1363.07. (a) Each health care service plan shall send copies  
38 of the comparative benefit matrix prepared pursuant to Section  
39 1363.06 on an annual basis, or more frequently as the matrix is  
40 updated by the department and the Department of Insurance, to

1 solicitors and solicitor firms and employers with whom the plan  
2 contracts.

3 (b) Each health care service plan shall require its representatives  
4 and solicitors and soliciting firms with which it contracts, to  
5 provide a copy of the comparative benefit matrix to individuals  
6 when presenting any benefit package for examination or sale.

7 (c) Each health care service plan that maintains an Internet Web  
8 site shall make a downloadable copy of the comparative benefit  
9 matrix described in Section 1363.06 available through a link on  
10 its site to the Internet Web sites of the department and the  
11 Department of Insurance.

12 (d) (1) *This section shall be inoperative on January 1, 2014.*

13 (2) *If Section 5000A of the Internal Revenue Code, as added by*  
14 *Section 1501 of PPACA, is repealed or amended to no longer apply*  
15 *to the individual market, as defined in Section 2791 of the federal*  
16 *Public Health Service Act (42 U.S.C. Sec. 300gg-91), this section*  
17 *shall become operative on the date of that repeal or amendment.*

18 (3) *For purposes of this subdivision, "PPACA" means the*  
19 *federal Patient Protection and Affordable Care Act (Public Law*  
20 *111-148), as amended by the federal Health Care Education and*  
21 *Reconciliation Act of 2010 (Public Law 111-152), and any rules,*  
22 *regulations, or guidance issued pursuant to that law.*

23 SEC. 3. *Section 1366.3 of the Health and Safety Code is*  
24 *amended to read:*

25 1366.3. (a) On and after January 1, 2005, a health care service  
26 plan issuing individual plan contracts that ceases to offer individual  
27 coverage in this state shall offer coverage to the subscribers who  
28 had been covered by those contracts at the time of withdrawal  
29 under the same terms and conditions as provided in paragraph (3)  
30 of subdivision (a), paragraphs (2) to (4), inclusive, of subdivision  
31 (b), subdivisions (c) to (e), inclusive, and subdivision (h) of Section  
32 1373.6.

33 (b) A health care service plan that ceases to offer individual  
34 coverage in a service area shall offer the coverage required by  
35 subdivision (a) to subscribers who had been covered by those  
36 contracts at the time of withdrawal, if the plan continues to offer  
37 group coverage in that service area. This subdivision shall not  
38 apply to coverage provided pursuant to a preferred provider  
39 organization.

1 (c) The department may adopt regulations to implement this  
2 section.

3 (d) This section shall not apply when a plan participating in  
4 Medi-Cal, Healthy Families, Access for Infants and Mothers, or  
5 any other contract between the plan and a government entity no  
6 longer contracts with the government entity to provide health  
7 coverage in the state, or a specified area of the state, nor shall this  
8 section apply when a plan ceases entirely to market, offer, and  
9 issue any and all forms of coverage in any part of this state after  
10 the effective date of this section.

11 (e) (1) *On and after January 1, 2014, and except as provided*  
12 *in paragraph (2), the reference to Section 1373.6 in subdivision*  
13 *(a) shall not apply to any health plan contracts.*

14 (2) *If Section 5000A of the Internal Revenue Code, as added by*  
15 *Section 1501 of the federal Patient Protection and Affordable Care*  
16 *Act (Public Law 111-148), as amended by the federal Health Care*  
17 *and Education Reconciliation Act of 2010 (Public Law 111-152),*  
18 *is repealed or amended to no longer apply to the individual market,*  
19 *as defined in Section 2791 of the federal Public Health Service*  
20 *Act (42 U.S.C. Section 300gg-91), paragraph (1) shall become*  
21 *inoperative on the date of that repeal or amendment.*

22 SEC. 4. *Section 1366.35 of the Health and Safety Code is*  
23 *amended to read:*

24 1366.35. (a) A health care service plan providing coverage  
25 for hospital, medical, or surgical benefits under an individual health  
26 care service plan contract may not, with respect to a federally  
27 eligible defined individual desiring to enroll in individual health  
28 insurance coverage, decline to offer coverage to, or deny enrollment  
29 of, the individual or impose any preexisting condition exclusion  
30 with respect to the coverage.

31 (b) For purposes of this section, “federally eligible defined  
32 individual” means an individual who, as of the date on which the  
33 individual seeks coverage under this section, meets all of the  
34 following conditions:

35 (1) Has had 18 or more months of creditable coverage, and  
36 whose most recent prior creditable coverage was under a group  
37 health plan, a federal governmental plan maintained for federal  
38 employees, or a governmental plan or church plan as defined in  
39 the federal Employee Retirement Income Security Act of 1974  
40 (29 U.S.C. Sec. 1002).

1 (2) Is not eligible for coverage under a group health plan,  
2 Medicare, or Medi-Cal, and does not have other health insurance  
3 coverage.

4 (3) Was not terminated from his or her most recent creditable  
5 coverage due to nonpayment of premiums or fraud.

6 (4) If offered continuation coverage under COBRA or  
7 Cal-COBRA, has elected and exhausted that coverage.

8 (c) Every health care service plan shall comply with applicable  
9 federal statutes and regulations regarding the provision of coverage  
10 to federally eligible defined individuals, including any relevant  
11 application periods.

12 (d) A health care service plan shall offer the following health  
13 benefit plan contracts under this section that are designed for, made  
14 generally available to, are actively marketed to, and enroll,  
15 individuals: (1) either the two most popular products as defined  
16 in Section 300gg-41(c)(2) of Title 42 of the United States Code  
17 and Section 148.120(c)(2) of Title 45 of the Code of Federal  
18 Regulations or (2) the two most representative products as defined  
19 in Section 300gg-41(c)(3) of the United States Code and Section  
20 148.120(c)(3) of Title 45 of the Code of Federal Regulations, as  
21 determined by the plan in compliance with federal law. A health  
22 care service plan that offers only one health benefit plan contract  
23 to individuals, excluding health benefit plans offered to Medi-Cal  
24 or Medicare beneficiaries, shall be deemed to be in compliance  
25 with this article if it offers that health benefit plan contract to  
26 federally eligible defined individuals in a manner consistent with  
27 this article.

28 (e) (1) In the case of a health care service plan that offers health  
29 insurance coverage in the individual market through a network  
30 plan, the plan may do both of the following:

31 (A) Limit the individuals who may be enrolled under that  
32 coverage to those who live, reside, or work within the service area  
33 for the network plan.

34 (B) Within the service area of the plan, deny coverage to  
35 individuals if the plan has demonstrated to the director that the  
36 plan will not have the capacity to deliver services adequately to  
37 additional individual enrollees because of its obligations to existing  
38 group contractholders and enrollees and individual enrollees, and  
39 that the plan is applying this paragraph uniformly to individuals  
40 without regard to any health status related factor of the individuals



1 and without regard to whether the individuals are federally eligible  
2 defined individuals.

3 (2) A health care service plan, upon denying health insurance  
4 coverage in any service area in accordance with subparagraph (B)  
5 of paragraph (1), may not offer coverage in the individual market  
6 within that service area for a period of 180 days after the coverage  
7 is denied.

8 (f) (1) A health care service plan may deny health insurance  
9 coverage in the individual market to a federally eligible defined  
10 individual if the plan has demonstrated to the director both of the  
11 following:

12 (A) The plan does not have the financial reserves necessary to  
13 underwrite additional coverage.

14 (B) The plan is applying this subdivision uniformly to all  
15 individuals in the individual market and without regard to any  
16 health status-related factor of the individuals and without regard  
17 to whether the individuals are federally eligible individuals.

18 (2) A health care service plan, upon denying individual health  
19 insurance coverage in any service area in accordance with  
20 paragraph (1), may not offer that coverage in the individual market  
21 within that service area for a period of 180 days after the date the  
22 coverage is denied or until the issuer has demonstrated to the  
23 director that the plan has sufficient financial reserves to underwrite  
24 additional coverage, whichever is later.

25 (g) The requirement pursuant to federal law to furnish a  
26 certificate of creditable coverage shall apply to health insurance  
27 coverage offered by a health care service plan in the individual  
28 market in the same manner as it applies to a health care service  
29 plan in connection with a group health benefit plan.

30 (h) A health care service plan shall compensate a life agent or  
31 fire and casualty broker-agent whose activities result in the  
32 enrollment of federally eligible defined individuals in the same  
33 manner and consistent with the renewal commission amounts as  
34 the plan compensates life agents or fire and casualty broker-agents  
35 for other enrollees who are not federally eligible defined  
36 individuals and who are purchasing the same individual health  
37 benefit plan contract.

38 (i) Every health care service plan shall disclose as part of its  
39 COBRA or Cal-COBRA disclosure and enrollment documents,  
40 an explanation of the availability of guaranteed access to coverage

1 under the Health Insurance Portability and Accountability Act of  
2 1996, including the necessity to enroll in and exhaust COBRA or  
3 Cal-COBRA benefits in order to become a federally eligible  
4 defined individual.

5 (j) No health care service plan may request documentation as  
6 to whether or not a person is a federally eligible defined individual  
7 other than is permitted under applicable federal law or regulations.

8 (k) This section shall not apply to coverage defined as excepted  
9 benefits pursuant to Section 300gg(c) of Title 42 of the United  
10 States Code.

11 ~~(l)~~

12 (l) This section shall apply to health care service plan contracts  
13 offered, delivered, amended, or renewed on or after January 1,  
14 2001.

15 (m) (1) *This section shall be inoperative on January 1, 2014.*

16 (2) *If Section 5000A of the Internal Revenue Code, as added by*  
17 *Section 1501 of PPACA, is repealed or amended to no longer apply*  
18 *to the individual market, as defined in Section 2791 of the federal*  
19 *Public Health Service Act (42 U.S.C. Section 300gg-91), this*  
20 *section shall become operative on the date of that repeal or*  
21 *amendment.*

22 (3) *For purposes of this subdivision, "PPACA" means the*  
23 *federal Patient Protection and Affordable Care Act (Public Law*  
24 *111-148), as amended by the federal Health Care Education and*  
25 *Reconciliation Act of 2010 (Public Law 111-152), and any rules,*  
26 *regulations, or guidance issued pursuant to that law.*

27 *SEC. 5. Section 1373.6 of the Health and Safety Code is*  
28 *amended to read:*

29 1373.6. This section does not apply to a specialized health care  
30 service plan contract or to a plan contract that primarily or solely  
31 supplements Medicare. The director may adopt rules consistent  
32 with federal law to govern the discontinuance and replacement of  
33 plan contracts that primarily or solely supplement Medicare.

34 (a) (1) Every group contract entered into, amended, or renewed  
35 on or after September 1, 2003, that provides hospital, medical, or  
36 surgical expense benefits for employees or members shall provide  
37 that an employee or member whose coverage under the group  
38 contract has been terminated by the employer shall be entitled to  
39 convert to nongroup membership, without evidence of insurability,  
40 subject to the terms and conditions of this section.

1 (2) If the health care service plan provides coverage under an  
2 individual health care service plan contract, other than conversion  
3 coverage under this section, it shall offer one of the two plans that  
4 it is required to offer to a federally eligible defined individual  
5 pursuant to Section 1366.35. The plan shall provide this coverage  
6 at the same rate established under Section 1399.805 for a federally  
7 eligible defined individual. A health care service plan that is  
8 federally qualified under the federal Health Maintenance  
9 Organization Act (42 U.S.C. Sec. 300e et seq.) may charge a rate  
10 for the coverage that is consistent with the provisions of that act.

11 (3) If the health care service plan does not provide coverage  
12 under an individual health care service plan contract, it shall offer  
13 a health benefit plan contract that is the same as a health benefit  
14 contract offered to a federally eligible defined individual pursuant  
15 to Section 1366.35. The health care service plan may offer either  
16 the most popular health maintenance organization model plan or  
17 the most popular preferred provider organization plan, each of  
18 which has the greatest number of enrolled individuals for its type  
19 of plan as of January 1 of the prior year, as reported by plans that  
20 provide coverage under an individual health care service plan  
21 contract to the department or the Department of Insurance by  
22 January 31, 2003, and annually thereafter. A health care service  
23 plan subject to this paragraph shall provide this coverage with the  
24 same cost-sharing terms and at the same premium as a health care  
25 service plan providing coverage to that individual under an  
26 individual health care service plan contract pursuant to Section  
27 1399.805. The health care service plan shall file the health benefit  
28 plan it will offer, including the premium it will charge and the  
29 cost-sharing terms of the plan, with the Department of Managed  
30 Health Care.

31 (b) A conversion contract shall not be required to be made  
32 available to an employee or member if termination of his or her  
33 coverage under the group contract occurred for any of the following  
34 reasons:

35 (1) The group contract terminated or an employer's participation  
36 terminated and the group contract is replaced by similar coverage  
37 under another group contract within 15 days of the date of  
38 termination of the group coverage or the subscriber's participation.

39 (2) The employee or member failed to pay amounts due the  
40 health care service plan.

1 (3) The employee or member was terminated by the health care  
2 service plan from the plan for good cause.

3 (4) The employee or member knowingly furnished incorrect  
4 information or otherwise improperly obtained the benefits of the  
5 plan.

6 (5) The employer's hospital, medical, or surgical expense benefit  
7 program is self-insured.

8 (c) A conversion contract is not required to be issued to any  
9 person if any of the following facts are present:

10 (1) The person is covered by or is eligible for benefits under  
11 Title XVIII of the United States Social Security Act.

12 (2) The person is covered by or is eligible for hospital, medical,  
13 or surgical benefits under any arrangement of coverage for  
14 individuals in a group, whether insured or self-insured.

15 (3) The person is covered for similar benefits by an individual  
16 policy or contract.

17 (4) The person has not been continuously covered during the  
18 three-month period immediately preceding that person's  
19 termination of coverage.

20 (d) Benefits of a conversion contract shall meet the requirements  
21 for benefits under this chapter.

22 (e) Unless waived in writing by the plan, written application  
23 and first premium payment for the conversion contract shall be  
24 made not later than 63 days after termination from the group. A  
25 conversion contract shall be issued by the plan which shall be  
26 effective on the day following the termination of coverage under  
27 the group contract if the written application and the first premium  
28 payment for the conversion contract are made to the plan not later  
29 than 63 days after the termination of coverage, unless these  
30 requirements are waived in writing by the plan.

31 (f) The conversion contract shall cover the employee or member  
32 and his or her dependents who were covered under the group  
33 contract on the date of their termination from the group.

34 (g) A notification of the availability of the conversion coverage  
35 shall be included in each evidence of coverage. However, it shall  
36 be the sole responsibility of the employer to notify its employees  
37 of the availability, terms, and conditions of the conversion coverage  
38 which responsibility shall be satisfied by notification within 15  
39 days of termination of group coverage. Group coverage shall not  
40 be deemed terminated until the expiration of any continuation of

1 the group coverage. For purposes of this subdivision, the employer  
2 shall not be deemed the agent of the plan for purposes of  
3 notification of the availability, terms, and conditions of conversion  
4 coverage.

5 (h) As used in this section, “hospital, medical, or surgical  
6 benefits under state or federal law” do not include benefits under  
7 Chapter 7 (commencing with Section 14000) or Chapter 8  
8 (commencing with Section 14200) of Part 3 of Division 9 of the  
9 Welfare and Institutions Code, or Title XIX of the United States  
10 Social Security Act.

11 (i) Every group contract entered into, amended, or renewed  
12 before September 1, 2003, shall be subject to the provisions of this  
13 section as it read prior to its amendment by Assembly Bill 1401  
14 of the 2001–02 Regular Session.

15 (j) *(1) On and after January 1, 2014, and except as provided*  
16 *in paragraph (2), this section shall apply only to individual*  
17 *grandfathered health plan contracts previously issued pursuant*  
18 *to this section to federally eligible defined individuals.*

19 *(2) If Section 5000A of the Internal Revenue Code, as added by*  
20 *Section 1501 of PPACA, is repealed or amended to no longer apply*  
21 *to the individual market, as defined in Section 2791 of the federal*  
22 *Public Health Service Act (42 U.S.C. Section 300gg-91), paragraph*  
23 *(1) shall become inoperative on the date of that repeal or*  
24 *amendment.*

25 *(3) For purposes of this subdivision, the following definitions*  
26 *apply:*

27 *(A) “Grandfathered health plan” has the same meaning as that*  
28 *term is defined in Section 1251 of the PPACA.*

29 *(B) “PPACA” means the federal Patient Protection and*  
30 *Affordable Care Act (Public Law 111-148), as amended by the*  
31 *federal Health Care Education and Reconciliation Act of 2010*  
32 *(Public Law 111-152), and any rules, regulations, or guidance*  
33 *issued pursuant to that law.*

34 *SEC. 6. Section 1373.620 is added to the Health and Safety*  
35 *Code, to read:*

36 *1373.620. (a) (1) At least 60 days prior to the plan renewal*  
37 *date, a health care service plan that does not otherwise issue*  
38 *individual health care service plan contracts shall issue the notice*  
39 *described in paragraph (2) to any subscriber enrolled in an*

1 individual health benefit plan contract issued pursuant to Section  
2 1373.6 that is not a grandfathered health plan.

3 (2) The notice shall be in at least 12-point type and shall include  
4 all of the following:

5 (A) Notice that, as of the renewal date, the individual plan  
6 contract will not be renewed.

7 (B) The availability of individual health coverage through  
8 Covered California, including at least all of the following:

9 (i) That, beginning on January 1, 2014, individuals seeking  
10 coverage may not be denied coverage based on health status.

11 (ii) That the premium rates for coverage offered by a health  
12 care service plan or a health insurer cannot be based on an  
13 individual's health status.

14 (iii) That individuals obtaining coverage through Covered  
15 California may, depending upon income, be eligible for premium  
16 subsidies and cost-sharing subsidies.

17 (iv) That individuals seeking coverage must obtain this coverage  
18 during an open or special enrollment period, and a description of  
19 the open and special enrollment periods that may apply.

20 (b) (1) At least 60 days prior to the plan renewal date, a health  
21 care service plan that issues individual health care service plan  
22 contracts shall issue the notice described in paragraph (2) to a  
23 subscriber enrolled in an individual health benefit plan contract  
24 issued pursuant to Section 1366.35 or 1373.6 that is not a  
25 grandfathered health plan.

26 (2) The notice shall be in at least 12-point type and shall include  
27 all of the following:

28 (A) Notice that, as of the renewal date, the individual plan  
29 contract will not be renewed.

30 (B) Information regarding the individual health plan contract  
31 that the health plan will issue as of January 1, 2014, which the  
32 health plan has reasonably concluded is the most comparable to  
33 the individual's current plan. The notice shall include information  
34 on premiums for the possible replacement plan and instructions  
35 that the individual can continue their coverage by paying the  
36 premium stated by the due date.

37 (C) Notice of the availability of other individual health coverage  
38 through Covered California, including at least all of the following:

39 (i) That, beginning on January 1, 2014, individuals seeking  
40 coverage may not be denied coverage based on health status.

1 (ii) That the premium rates for coverage offered by a health  
2 care service plan or a health insurer cannot be based on an  
3 individual's health status.

4 (iii) That individuals obtaining coverage through Covered  
5 California may, depending upon income, be eligible for premium  
6 subsidies and cost-sharing subsidies.

7 (iv) That individuals seeking coverage must obtain this coverage  
8 during an open or special enrollment period, and a description of  
9 the open and special enrollment periods that may apply.

10 (c) No later than September 1, 2013, the department, in  
11 consultation with the Department of Insurance, shall adopt uniform  
12 model notices that health plans shall use to comply with  
13 subdivisions (a) and (b). Use of the model notices shall not require  
14 prior approval by the department. The model notices adopted by  
15 the department for purposes of this section shall not be subject to  
16 the Administrative Procedure Act (Chapter 3.5 (commencing with  
17 Section 11340) of Part 1 of Division 3 of Title 2 of the Government  
18 Code).

19 (d) For purposes of this section, the following definitions shall  
20 apply:

21 (1) "Covered California" means the California Health Benefit  
22 Exchange established pursuant to Section 100500 of the  
23 Government Code.

24 (2) "Grandfathered health plan" has the same meaning as that  
25 term is defined in Section 1251 of PPACA.

26 (3) "PPACA" means the federal Patient Protection and  
27 Affordable Care Act (Public Law 111-148), as amended by the  
28 federal Health Care and Education Reconciliation Act of 2010  
29 (Public Law 111-152), and any rules, regulations, or guidance  
30 issued pursuant to that law.

31 ~~SEC. 2.~~

32 SEC. 7. Section 1373.621 of the Health and Safety Code is  
33 amended to read:

34 1373.621. (a) Except for a specialized health care service plan,  
35 every health care service plan contract that is issued, amended,  
36 delivered, or renewed in this state on or after January 1, 1999, that  
37 provides hospital, medical, or surgical expense coverage under an  
38 employer-sponsored group plan for an employer subject to  
39 COBRA, as defined in subdivision (e), or an employer group for  
40 which the plan is required to offer Cal-COBRA coverage, as

1 defined in subdivision (f), including a carrier providing replacement  
2 coverage under Section 1399.63, shall further offer the former  
3 employee the opportunity to continue benefits as required under  
4 subdivision (b), and shall further offer the former spouse of an  
5 employee or former employee the opportunity to continue benefits  
6 as required under subdivision (c).

7 (b) (1) In the event a former employee who worked for the  
8 employer for at least five years prior to the date of termination of  
9 employment and who is 60 years of age or older on the date  
10 employment ends is entitled to and so elects to continue benefits  
11 under COBRA or Cal-COBRA for himself or herself and for any  
12 spouse, the employee or spouse may further continue benefits  
13 beyond the date coverage under COBRA or Cal-COBRA ends, as  
14 set forth in paragraph (2). Except as otherwise specified,  
15 continuation coverage shall be under the same benefit terms and  
16 conditions as if the continuation coverage under COBRA or  
17 Cal-COBRA had remained in force. For the employee or spouse,  
18 continuation coverage following the end of COBRA or  
19 Cal-COBRA is subject to payment of premiums to the health care  
20 service plan. Individuals ineligible for COBRA or Cal-COBRA,  
21 or who are eligible but have not elected or exhausted continuation  
22 coverage under federal COBRA or Cal-COBRA, are not entitled  
23 to continuation coverage under this section. Premiums for  
24 continuation coverage under this section shall be billed by, and  
25 remitted to, the health care service plan in accordance with  
26 subdivision (d). Failure to pay the requisite premiums may result  
27 in termination of the continuation coverage in accordance with the  
28 applicable provisions in the plan's group subscriber agreement  
29 with the former employer.

30 (2) The employer shall notify the former employee or spouse  
31 or both, or the former spouse of the employee or former employee,  
32 of the availability of the continuation benefits under this section  
33 in accordance with Section 2800.2 of the Labor Code. To continue  
34 health care coverage pursuant to this section, the individual shall  
35 elect to do so by notifying the plan in writing within 30 calendar  
36 days prior to the date continuation coverage under COBRA or  
37 Cal-COBRA is scheduled to end. Every health care service plan  
38 and specialized health care service plan shall provide to the  
39 employer replacing a health care service plan contract issued by  
40 the plan, or to the employer's agent or broker representative, within



1 15 days of any written request, information in possession of the  
2 plan reasonably required to administer the requirements of Section  
3 2800.2 of the Labor Code.

4 (3) The continuation coverage shall end automatically on the  
5 earlier of (A) the date the individual reaches age 65, (B) the date  
6 the individual is covered under any group health plan not  
7 maintained by the employer or any other health plan, regardless  
8 of whether that coverage is less valuable, (C) the date the individual  
9 becomes entitled to Medicare under Title XVIII of the Social  
10 Security Act, (D) for a spouse, five years from the date on which  
11 continuation coverage under COBRA or Cal-COBRA was  
12 scheduled to end for the spouse, or (E) the date on which the  
13 employer terminates its group subscriber agreement with the health  
14 care service plan and ceases to provide coverage for any active  
15 employees through that plan, in which case the health care service  
16 plan shall notify the former employee or spouse or both of the right  
17 to a conversion plan in accordance with Section 1373.6.

18 (c) (1) If a former spouse of an employee or former employee  
19 was covered as a qualified beneficiary under COBRA or  
20 Cal-COBRA, the former spouse may further continue benefits  
21 beyond the date coverage under COBRA or Cal-COBRA ends, as  
22 set forth in paragraph (2) of subdivision (b). Except as otherwise  
23 specified in this section, continuation coverage shall be under the  
24 same benefit terms and conditions as if the continuation coverage  
25 under COBRA or Cal-COBRA had remained in force. Continuation  
26 coverage following the end of COBRA or Cal-COBRA is subject  
27 to payment of premiums to the health care service plan. Premiums  
28 for continuation coverage under this section shall be billed by, and  
29 remitted to, the health care service plan in accordance with  
30 subdivision (d). Failure to pay the requisite premiums may result  
31 in termination of the continuation coverage in accordance with the  
32 applicable provisions in the plan's group subscriber agreement  
33 with the employer or former employer.

34 (2) The continuation coverage for the former spouse shall end  
35 automatically on the earlier of (A) the date the individual reaches  
36 65 years of age, (B) the date the individual is covered under any  
37 group health plan not maintained by the employer or any other  
38 health plan, regardless of whether that coverage is less valuable,  
39 (C) the date the individual becomes entitled to Medicare under  
40 Title XVIII of the Social Security Act, (D) five years from the date

1 on which continuation coverage under COBRA or Cal-COBRA  
2 was scheduled to end for the former spouse, or (E) the date on  
3 which the employer or former employer terminates its group  
4 subscriber agreement with the health care service plan and ceases  
5 to provide coverage for any active employees through that plan.

6 (d) (1) If the premium charged to the employer for a specific  
7 employee or dependent eligible under this section is adjusted for  
8 the age of the specific employee, or eligible dependent, on other  
9 than a composite basis, the rate for continuation coverage under  
10 this section shall not exceed 102 percent of the premium charged  
11 by the plan to the employer for an employee of the same age as  
12 the former employee electing continuation coverage in the case of  
13 an individual who was eligible for COBRA, and 110 percent in  
14 the case of an individual who was eligible for Cal-COBRA. If the  
15 coverage continued is that of a former spouse, the premium charged  
16 shall not exceed 102 percent of the premium charged by the plan  
17 to the employer for an employee of the same age as the former  
18 spouse selecting continuation coverage in the case of an individual  
19 who was eligible for COBRA, and 110 percent in the case of an  
20 individual who was eligible for Cal-COBRA.

21 (2) If the premium charged to the employer for a specific  
22 employee or dependent eligible under this section is not adjusted  
23 for age of the specific employee, or eligible dependent, then the  
24 rate for continuation coverage under this section shall not exceed  
25 213 percent of the applicable current group rate. For purposes of  
26 this section, the “applicable current group rate” means the total  
27 premiums charged by the health care service plan for coverage for  
28 the group, divided by the relevant number of covered persons.

29 (3) However, in computing the premiums charged to the specific  
30 employer group, the health care service plan shall not include  
31 consideration of the specific medical care expenditures for  
32 beneficiaries receiving continuation coverage pursuant to this  
33 section.

34 (e) For purposes of this section, “COBRA” means Section  
35 4980B of Title 26 of the United States Code, Section 1161 et seq.  
36 of Title 29 of the United States Code, and Section 300bb of Title  
37 42 of the United States Code, as added by the Consolidated  
38 Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272),  
39 and as amended.

1 (f) For purposes of this section, “Cal-COBRA” means the  
2 continuation coverage that must be offered pursuant to Article 4.5  
3 (commencing with Section 1366.20), or Article 1.7 (commencing  
4 with Section 10128.50) of Chapter 1 of Part 2 of Division 2 of the  
5 Insurance Code.

6 (g) For the purposes of this section, “former spouse” means  
7 either an individual who is divorced from an employee or former  
8 employee or an individual who was married to an employee or  
9 former employee at the time of the death of the employee or former  
10 employee.

11 (h) Every plan evidence of coverage that is issued, amended,  
12 or renewed after July 1, 1999, shall contain a description of the  
13 provisions and eligibility requirements for the continuation  
14 coverage offered pursuant to this section.

15 (i) This section does not apply to any individual who is not  
16 eligible for its continuation coverage prior to January 1, 2005.

17 ~~SEC. 3.~~

18 *SEC. 8.* Section 1389.5 of the Health and Safety Code is  
19 amended to read:

20 1389.5. (a) This section shall apply to a health care service  
21 plan that provides coverage under an individual plan contract that  
22 is issued, amended, delivered, or renewed on or after January 1,  
23 2007.

24 (b) At least once each year, the health care service plan shall  
25 permit an individual who has been covered for at least 18 months  
26 under an individual plan contract to transfer, without medical  
27 underwriting, to any other individual plan contract offered by that  
28 same health care service plan that provides equal or lesser benefits,  
29 as determined by the plan.

30 “Without medical underwriting” means that the health care  
31 service plan shall not decline to offer coverage to, or deny  
32 enrollment of, the individual or impose any preexisting condition  
33 exclusion on the individual who transfers to another individual  
34 plan contract pursuant to this section.

35 (c) The plan shall establish, for the purposes of subdivision (b),  
36 a ranking of the individual plan contracts it offers to individual  
37 purchasers and post the ranking on its Internet Web site or make  
38 the ranking available upon request. The plan shall update the  
39 ranking whenever a new benefit design for individual purchasers  
40 is approved.

(d) The plan shall notify in writing all enrollees of the right to transfer to another individual plan contract pursuant to this section, at a minimum, when the plan changes the enrollee's premium rate. Posting this information on the plan's Internet Web site shall not constitute notice for purposes of this subdivision. The notice shall adequately inform enrollees of the transfer rights provided under this section, including information on the process to obtain details about the individual plan contracts available to that enrollee and advising that the enrollee may be unable to return to his or her current individual plan contract if the enrollee transfers to another individual plan contract.

(e) The requirements of this section shall not apply to the following:

(1) A federally eligible defined individual, as defined in subdivision (c) of Section 1399.801, who is enrolled in an individual health benefit plan contract offered pursuant to Section 1366.35.

(2) An individual offered conversion coverage pursuant to Section 1373.6.

(3) Individual coverage under a specialized health care service plan contract.

(4) An individual enrolled in the Medi-Cal program pursuant to Chapter 7 (commencing with Section 14000) of Division 9 of Part 3 of the Welfare and Institutions Code.

(5) An individual enrolled in the Access for Infants and Mothers Program pursuant to Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code.

(6) An individual enrolled in the Healthy Families Program pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code.

(f) It is the intent of the Legislature that individuals shall have more choice in their health coverage when health care service plans guarantee the right of an individual to transfer to another product based on the plan's own ranking system. The Legislature does not intend for the department to review or verify the plan's ranking for actuarial or other purposes.

(g) (1) This section shall be inoperative on January 1, 2014.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the

1 federal Public Health Service Act (42 U.S.C. Sec. ~~300gg-04~~);  
2 ~~300gg-91~~), this section shall become operative on the date of that  
3 repeal or amendment.

4 (3) For purposes of this subdivision, “PPACA” means the federal  
5 Patient Protection and Affordable Care Act (Public Law 111-148),  
6 as amended by the federal Health Care and Education  
7 Reconciliation Act of 2010 (Public Law 111-152), and any rules,  
8 regulations, or guidance issued pursuant to that law.

9 *SEC. 9. Section 1399.805 of the Health and Safety Code is*  
10 *amended to read:*

11 1399.805. (a) (1) After the federally eligible defined  
12 individual submits a completed application form for a plan contract,  
13 the plan shall, within 30 days, notify the individual of the  
14 individual’s actual premium charges for that plan contract, unless  
15 the plan has provided notice of the premium charge prior to the  
16 application being filed. In no case shall the premium charged for  
17 any health care service plan contract identified in subdivision (d)  
18 of Section 1366.35 exceed the following amounts:

19 (A) For health care service plan contracts that offer services  
20 through a preferred provider arrangement, the average premium  
21 paid by a subscriber of the Major Risk Medical Insurance Program  
22 who is of the same age and resides in the same geographic area as  
23 the federally eligible defined individual. However, for federally  
24 qualified individuals who are between the ages of 60 and 64,  
25 inclusive, the premium shall not exceed the average premium paid  
26 by a subscriber of the Major Risk Medical Insurance Program who  
27 is 59 years of age and resides in the same geographic area as the  
28 federally eligible defined individual.

29 (B) For health care service plan contracts identified in  
30 subdivision (d) of Section 1366.35 that do not offer services  
31 through a preferred provider arrangement, 170 percent of the  
32 standard premium charged to an individual who is of the same age  
33 and resides in the same geographic area as the federally eligible  
34 defined individual. However, for federally qualified individuals  
35 who are between the ages of 60 and 64, inclusive, the premium  
36 shall not exceed 170 percent of the standard premium charged to  
37 an individual who is 59 years of age and resides in the same  
38 geographic area as the federally eligible defined individual. The  
39 individual shall have 30 days in which to exercise the right to buy  
40 coverage at the quoted premium rates.

1 (2) A plan may adjust the premium based on family size, not to  
2 exceed the following amounts:

3 (A) For health care service plans that offer services through a  
4 preferred provider arrangement, the average of the Major Risk  
5 Medical Insurance Program rate for families of the same size that  
6 reside in the same geographic area as the federally eligible defined  
7 individual.

8 (B) For health care service plans identified in subdivision (d)  
9 of Section 1366.35 that do not offer services through a preferred  
10 provider arrangement, 170 percent of the standard premium charged  
11 to a family that is of the same size and resides in the same  
12 geographic area as the federally eligible defined individual.

13 (b) When a federally eligible defined individual submits a  
14 premium payment, based on the quoted premium charges, and that  
15 payment is delivered or postmarked, whichever occurs earlier,  
16 within the first 15 days of the month, coverage shall begin no later  
17 than the first day of the following month. When that payment is  
18 neither delivered or postmarked until after the 15th day of a month,  
19 coverage shall become effective no later than the first day of the  
20 second month following delivery or postmark of the payment.

21 (c) During the first 30 days after the effective date of the plan  
22 contract, the individual shall have the option of changing coverage  
23 to a different plan contract offered by the same health care service  
24 plan. If the individual notified the plan of the change within the  
25 first 15 days of a month, coverage under the new plan contract  
26 shall become effective no later than the first day of the following  
27 month. If an enrolled individual notified the plan of the change  
28 after the 15th day of a month, coverage under the new plan contract  
29 shall become effective no later than the first day of the second  
30 month following notification.

31 *(d) (1) On and after January 1, 2014, and except as provided*  
32 *in paragraph (2), this section shall apply only to individual*  
33 *grandfathered health plan contracts previously issued pursuant*  
34 *to this section to federally eligible defined individuals.*

35 *(2) If Section 5000A of the Internal Revenue Code, as added by*  
36 *Section 1501 of PPACA, is repealed or amended to no longer apply*  
37 *to the individual market, as defined in Section 2791 of the federal*  
38 *Public Health Service Act (42 U.S.C. Section 300gg-91), paragraph*  
39 *(1) shall become inoperative on the date of that repeal or*

1 *amendment and this section shall apply to health care service plan*  
2 *contracts issued, amended, or renewed on or after that date.*

3 *(3) For purposes of this subdivision, the following definitions*  
4 *apply:*

5 *(A) "Grandfathered health plan" has the same meaning as that*  
6 *term is defined in Section 1251 of the PPACA.*

7 *(B) "PPACA" means the federal Patient Protection and*  
8 *Affordable Care Act (Public Law 111-148), as amended by the*  
9 *federal Health Care Education and Reconciliation Act of 2010*  
10 *(Public Law 111-152), and any rules, regulations, or guidance*  
11 *issued pursuant to that law.*

12 *SEC. 10. Section 1399.810 of the Health and Safety Code is*  
13 *amended to read:*

14 1399.810. All health care service plan contracts offered to a  
15 federally eligible defined individual shall be renewable with respect  
16 to the individual and dependents at the option of the contractholder  
17 except in cases of:

18 (a) Nonpayment of the required premiums.

19 (b) Fraud or misrepresentation by the contractholder.

20 (c) The plan ceases to provide or arrange for the provision of  
21 health care services for individual health care service plan contracts  
22 in this state, provided, however, that the following conditions are  
23 satisfied:

24 (1) Notice of the decision to cease new or existing individual  
25 health benefit plans in this state is provided to the director and to  
26 the contractholder.

27 (2) Individual health care service plan contracts subject to this  
28 chapter shall not be canceled for 180 days after the date of the  
29 notice required under paragraph (1) and for that business of a plan  
30 that remains in force, any plan that ceases to offer for sale new  
31 individual health care service plan contracts shall continue to be  
32 governed by this article with respect to business conducted under  
33 this article.

34 (3) A plan that ceases to write new individual business in this  
35 state after January 1, 2001, shall be prohibited from offering for  
36 sale new individual health care service plan contracts in this state  
37 for a period of three years from the date of the notice to the director.

38 (d) When the plan withdraws a health care service plan contract  
39 from the individual market, provided that the plan makes available  
40 to eligible individuals all plan contracts that it makes available to

1 new individual business, and provided that the premium for the  
2 new plan contract complies with the renewal increase requirements  
3 set forth in Section 1399.811.

4 *(e) (1) On and after January 1, 2014, and except as provided*  
5 *in paragraph (2), this section shall apply only to individual*  
6 *grandfathered health plan contracts previously issued pursuant*  
7 *to this section to federally eligible defined individuals.*

8 *(2) If Section 5000A of the Internal Revenue Code, as added by*  
9 *Section 1501 of PPACA, is repealed or amended to no longer apply*  
10 *to the individual market, as defined in Section 2791 of the federal*  
11 *Public Health Service Act (42 U.S.C. Section 300gg-91), paragraph*  
12 *(1) shall become inoperative on the date of that repeal or*  
13 *amendment and this section shall apply to health care service plan*  
14 *contracts issued, amended, or renewed on or after that date.*

15 *(3) For purposes of this subdivision, the following definitions*  
16 *apply:*

17 *(A) "Grandfathered health plan" has the same meaning as that*  
18 *term is defined in Section 1251 of the PPACA.*

19 *(B) "PPACA" means the federal Patient Protection and*  
20 *Affordable Care Act (Public Law 111-148), as amended by the*  
21 *federal Health Care Education and Reconciliation Act of 2010*  
22 *(Public Law 111-152), and any rules, regulations, or guidance*  
23 *issued pursuant to that law.*

24 *SEC. 11. Section 1399.811 of the Health and Safety Code is*  
25 *amended to read:*

26 1399.811. Premiums for contracts offered, delivered, amended,  
27 or renewed by plans on or after January 1, 2001, shall be subject  
28 to the following requirements:

29 (a) The premium for new business for a federally eligible defined  
30 individual shall not exceed the following amounts:

31 (1) For health care service plan contracts identified in  
32 subdivision (d) of Section 1366.35 that offer services through a  
33 preferred provider arrangement, the average premium paid by a  
34 subscriber of the Major Risk Medical Insurance Program who is  
35 of the same age and resides in the same geographic area as the  
36 federally eligible defined individual. However, for federally  
37 qualified individuals who are between the ages of 60 to 64 years,  
38 inclusive, the premium shall not exceed the average premium paid  
39 by a subscriber of the Major Risk Medical Insurance Program who



1 is 59 years of age and resides in the same geographic area as the  
2 federally eligible defined individual.

3 (2) For health care service plan contracts identified in  
4 subdivision (d) of Section 1366.35 that do not offer services  
5 through a preferred provider arrangement, 170 percent of the  
6 standard premium charged to an individual who is of the same age  
7 and resides in the same geographic area as the federally eligible  
8 defined individual. However, for federally qualified individuals  
9 who are between the ages of 60 to 64 years, inclusive, the premium  
10 shall not exceed 170 percent of the standard premium charged to  
11 an individual who is 59 years of age and resides in the same  
12 geographic area as the federally eligible defined individual.

13 (b) The premium for in force business for a federally eligible  
14 defined individual shall not exceed the following amounts:

15 (1) For health care service plan contracts identified in  
16 subdivision (d) of Section 1366.35 that offer services through a  
17 preferred provider arrangement, the average premium paid by a  
18 subscriber of the Major Risk Medical Insurance Program who is  
19 of the same age and resides in the same geographic area as the  
20 federally eligible defined individual. However, for federally  
21 qualified individuals who are between the ages of 60 and 64 years,  
22 inclusive, the premium shall not exceed the average premium paid  
23 by a subscriber of the Major Risk Medical Insurance Program who  
24 is 59 years of age and resides in the same geographic area as the  
25 federally eligible defined individual.

26 (2) For health care service plan contracts identified in  
27 subdivision (d) of Section 1366.35 that do not offer services  
28 through a preferred provider arrangement, 170 percent of the  
29 standard premium charged to an individual who is of the same age  
30 and resides in the same geographic area as the federally eligible  
31 defined individual. However, for federally qualified individuals  
32 who are between the ages of 60 and 64 years, inclusive, the  
33 premium shall not exceed 170 percent of the standard premium  
34 charged to an individual who is 59 years of age and resides in the  
35 same geographic area as the federally eligible defined individual.  
36 The premium effective on January 1, 2001, shall apply to in force  
37 business at the earlier of either the time of renewal or July 1, 2001.

38 (c) The premium applied to a federally eligible defined  
39 individual may not increase by more than the following amounts:

(1) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that offer services through a preferred provider arrangement, the average increase in the premiums charged to a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual.

(2) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement, the increase in premiums charged to a nonfederally qualified individual who is of the same age and resides in the same geographic area as the federally defined eligible individual. The premium for an eligible individual may not be modified more frequently than every 12 months.

(3) For a contract that a plan has discontinued offering, the premium applied to the first rating period of the new contract that the federally eligible defined individual elects to purchase shall be no greater than the premium applied in the prior rating period to the discontinued contract.

*(d) (1) On and after January 1, 2014, and except as provided in paragraph (2), this section shall apply only to individual grandfathered health plan contracts previously issued pursuant to this section to federally eligible defined individuals.*

*(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Section 300gg-91), paragraph (1) shall become inoperative on the date of that repeal or amendment and this section shall apply to health care service plan contracts issued, amended, or renewed on or after that date.*

*(3) For purposes of this subdivision, the following definitions apply:*

*(A) "Grandfathered health plan" has the same meaning as that term is defined in Section 1251 of the PPACA.*

*(B) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care Education and Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.*

*SEC. 12. Section 1399.815 of the Health and Safety Code is amended to read:*

1399.815. (a) At least 20 business days prior to renewing or amending a plan contract subject to this article, or at least 20 business days prior to the initial offering of a plan contract subject to this article, a plan shall file a notice of an amendment with the director in accordance with the provisions of Section 1352. The notice of an amendment shall include a statement certifying that the plan is in compliance with subdivision (a) of Section 1399.805 and with Section 1399.811. Any action by the director, as permitted under Section 1352, to disapprove, suspend, or postpone the plan's use of a plan contract shall be in writing, specifying the reasons the plan contract does not comply with the requirements of this chapter.

(b) Prior to making any changes in the premium, the plan shall file an amendment in accordance with the provisions of Section 1352, and shall include a statement certifying the plan is in compliance with subdivision (a) of Section 1399.805 and with Section 1399.811. All other changes to a plan contract previously filed with the director pursuant to subdivision (a) shall be filed as an amendment in accordance with the provisions of Section 1352, unless the change otherwise would require the filing of a material modification.

(c) (1) *On and after January 1, 2014, and except as provided in paragraph (2), this section shall apply only to individual grandfathered health plan contracts previously issued pursuant to this section to federally eligible defined individuals.*

(2) *If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Section 300gg-91), paragraph (1) shall become inoperative on the date of that repeal or amendment and this section shall apply to plan contracts issued, amended, or renewed on or after that date.*

(3) *For purposes of this subdivision, the following definitions apply:*

(A) *"Grandfathered health plan" has the same meaning as that term is defined in Section 1251 of the PPACA.*

(B) *"PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care Education and Reconciliation Act of 2010*

1 *(Public Law 111-152), and any rules, regulations, or guidance*  
2 *issued pursuant to that law.*

3 ~~SEC. 4. Section 1399.816 of the Health and Safety Code is~~  
4 ~~repealed.~~

5 ~~SEC. 5. Section 1399.818 of the Health and Safety Code is~~  
6 ~~repealed.~~

7 ~~SEC. 6. Section 1399.818 is added to the Health and Safety~~  
8 ~~Code, to read:~~

9 ~~1399.818. (a) On and after January 1, 2014, this article and~~  
10 ~~Sections 1366.35 and 1373.6 shall apply only to grandfathered~~  
11 ~~individual health plan contracts previously issued to federally~~  
12 ~~eligible defined individuals.~~

13 ~~(b) If Section 5000A of the Internal Revenue Code, as added~~  
14 ~~by Section 1501 of PPACA, is repealed or amended to no longer~~  
15 ~~apply to the individual market, as defined in Section 2791 of the~~  
16 ~~federal Public Health Service Act (42 U.S.C. Sec. 300gg-04), this~~  
17 ~~section shall become inoperative and shall be repealed on January~~  
18 ~~1 following the date that it becomes inoperative.~~

19 ~~(c) For purposes of this section, the following definitions apply:~~

20 ~~(1) “Grandfathered health plan” has the same meaning as that~~  
21 ~~term is defined in Section 1251 of PPACA.~~

22 ~~(2) “PPACA” means the federal Patient Protection and~~  
23 ~~Affordable Care Act (Public Law 111-148), as amended by the~~  
24 ~~federal Health Care and Education Reconciliation Act of 2010~~  
25 ~~(Public Law 111-152), and any rules, regulations, or guidance~~  
26 ~~issued pursuant to that law.~~

27 ~~SEC. 7.~~

28 ~~SEC. 13. Section 10116.5 of the Insurance Code is amended~~  
29 ~~to read:~~

30 ~~10116.5. (a) Every policy of disability insurance that is issued,~~  
31 ~~amended, delivered, or renewed in this state on or after January~~  
32 ~~1, 1999, that provides hospital, medical, or surgical expense~~  
33 ~~coverage under an employer-sponsored group plan for an employer~~  
34 ~~subject to COBRA, as defined in subdivision (e), or an employer~~  
35 ~~group for which the disability insurer is required to offer~~  
36 ~~Cal-COBRA coverage, as defined in subdivision (f), including a~~  
37 ~~carrier providing replacement coverage under Section 10128.3,~~  
38 ~~shall further offer the former employee the opportunity to continue~~  
39 ~~benefits as required under subdivision (b), and shall further offer~~

1 the former spouse of an employee or former employee the  
2 opportunity to continue benefits as required under subdivision (c).

3 (b) (1) If a former employee worked for the employer for at  
4 least five years prior to the date of termination of employment and  
5 is 60 years of age or older on the date employment ends is entitled  
6 to and so elects to continue benefits under COBRA or Cal-COBRA  
7 for himself or herself and for any spouse, the employee or spouse  
8 may further continue benefits beyond the date coverage under  
9 COBRA or Cal-COBRA ends, as set forth in paragraph (2). Except  
10 as otherwise specified in this section, continuation coverage shall  
11 be under the same benefit terms and conditions as if the  
12 continuation coverage under COBRA or Cal-COBRA had remained  
13 in force. For the employee or spouse, continuation coverage  
14 following the end of COBRA or Cal-COBRA is subject to payment  
15 of premiums to the insurer. Individuals ineligible for COBRA or  
16 Cal-COBRA or who are eligible but have not elected or exhausted  
17 continuation coverage under federal COBRA or Cal-COBRA are  
18 not entitled to continuation coverage under this section. Premiums  
19 for continuation coverage under this section shall be billed by, and  
20 remitted to, the insurer in accordance with subdivision (d). Failure  
21 to pay the requisite premiums may result in termination of the  
22 continuation coverage in accordance with the applicable provisions  
23 in the insurer's group contract with the employer.

24 (2) The employer shall notify the former employee or spouse  
25 or both, or the former spouse of the employee or former employee,  
26 of the availability of the continuation benefits under this section  
27 in accordance with Section 2800.2 of the Labor Code. To continue  
28 health care coverage pursuant to this section, the individual shall  
29 elect to do so by notifying the insurer in writing within 30 calendar  
30 days prior to the date continuation coverage under COBRA or  
31 Cal-COBRA is scheduled to end. Every disability insurer shall  
32 provide to the employer replacing a group benefit plan policy  
33 issued by the insurer, or to the employer's agent or broker  
34 representative, within 15 days of any written request, information  
35 in possession of the insurer reasonably required to administer the  
36 requirements of Section 2800.2 of the Labor Code.

37 (3) The continuation coverage shall end automatically on the  
38 earlier of (A) the date the individual reaches age 65, (B) the date  
39 the individual is covered under any group health plan not  
40 maintained by the employer or any other insurer or health care

1 service plan, regardless of whether that coverage is less valuable,  
2 (C) the date the individual becomes entitled to Medicare under  
3 Title XVIII of the Social Security Act, (D) for a spouse, five years  
4 from the date on which continuation coverage under COBRA or  
5 Cal-COBRA was scheduled to end for the spouse, or (E) the date  
6 on which the employer terminates its group contract with the  
7 insurer and ceases to provide coverage for any active employees  
8 through that insurer, in which case the insurer shall notify the  
9 former employee or spouse, or both, of the right to a conversion  
10 policy.

11 (c) (1) If a former spouse of an employee or former employee  
12 was covered as a qualified beneficiary under COBRA or  
13 Cal-COBRA, the former spouse may further continue benefits  
14 beyond the date coverage under COBRA or Cal-COBRA ends, as  
15 set forth in paragraph (2) of subdivision (b). Except as otherwise  
16 specified in this section, continuation coverage shall be under the  
17 same benefit terms and conditions as if the continuation coverage  
18 under COBRA or Cal-COBRA had remained in force. Continuation  
19 coverage following the end of COBRA or Cal-COBRA is subject  
20 to payment of premiums to the insurer. Premiums for continuation  
21 coverage under this section shall be billed by, and remitted to, the  
22 insurer in accordance with subdivision (d). Failure to pay the  
23 requisite premiums may result in termination of the continuation  
24 coverage in accordance with the applicable provisions in the  
25 insurer's group contract with the employer or former employer.

26 (2) The continuation coverage for the former spouse shall end  
27 automatically on the earlier of (A) the date the individual reaches  
28 65 years of age, (B) the date the individual is covered under any  
29 group health plan not maintained by the employer or any other  
30 health care service plan or insurer, regardless of whether that  
31 coverage is less valuable, (C) the date the individual becomes  
32 entitled to Medicare under Title XVIII of the Social Security Act,  
33 (D) five years from the date on which continuation coverage under  
34 COBRA or Cal-COBRA was scheduled to end for the former  
35 spouse, or (E) the date on which the employer or former employer  
36 terminates its group contract with the insurer and ceases to provide  
37 coverage for any active employees through that insurer.

38 (d) (1) If the premium charged to the employer for a specific  
39 employee or dependent eligible under this section is adjusted for  
40 the age of the specific employee, or eligible dependent, on other

1 than a composite basis, the rate for continuation coverage under  
2 this section shall not exceed 102 percent of the premium charged  
3 by the insurer to the employer for an employee of the same age as  
4 the former employee electing continuation coverage in the case of  
5 an individual who was eligible for COBRA, and 110 percent in  
6 the case of an individual who was eligible for Cal-COBRA. If the  
7 coverage continued is that of a former spouse, the premium charged  
8 shall not exceed 102 percent of the premium charged by the plan  
9 to the employer for an employee of the same age as the former  
10 spouse selecting continuation coverage in the case of an individual  
11 who was eligible for COBRA, and 110 percent in the case of an  
12 individual who was eligible for Cal-COBRA.

13 (2) If the premium charged to the employer for a specific  
14 employee or dependent eligible under this section is not adjusted  
15 for age of the specific employee, or eligible dependent, then the  
16 rate for continuation coverage under this section shall not exceed  
17 213 percent of the applicable current group rate. For purposes of  
18 this section, the “applicable current group rate” means the total  
19 premiums charged by the insurer for coverage for the group,  
20 divided by the relevant number of covered persons.

21 (3) However, in computing the premiums charged to the specific  
22 employer group, the insurer shall not include consideration of the  
23 specific medical care expenditures for beneficiaries receiving  
24 continuation coverage pursuant to this section.

25 (e) For purposes of this section, “COBRA” means Section  
26 4980B of Title 26, Section 1161 and following of Title 29, and  
27 Section 300bb of Title 42 of the United States Code, as added by  
28 the Consolidated Omnibus Budget Reconciliation Act of 1985  
29 ~~(P.L.~~ (*Public Law* 99-272), and as amended.

30 (f) For purposes of this section, “Cal-COBRA” means the  
31 continuation coverage that must be offered pursuant to Article 1.7  
32 (commencing with Section 10128.50), or Article 4.5 (commencing  
33 with Section 1366.20) of Chapter 2.2 of Division 2 of the Health  
34 and Safety Code.

35 (g) For the purposes of this section, “former spouse” means  
36 either an individual who is divorced from an employee or former  
37 employee or an individual who was married to an employee or  
38 former employee at the time of the death of the employee or former  
39 employee.

1 (h) Every group benefit plan evidence of coverage that is issued,  
2 amended, or renewed after January 1, 1999, shall contain a  
3 description of the provisions and eligibility requirements for the  
4 continuation coverage offered pursuant to this section.

5 (i) This section does not apply to any individual who is not  
6 eligible for its continuation coverage prior to January 1, 2005.

7 ~~SEC. 8.~~

8 *SEC. 14.* Section 10119.1 of the Insurance Code is amended  
9 to read:

10 10119.1. (a) This section shall apply to a health insurer that  
11 covers hospital, medical, or surgical expenses under an individual  
12 health benefit plan, as defined in subdivision (a) of Section  
13 10198.6, that is issued, amended, renewed, or delivered on or after  
14 January 1, 2007.

15 (b) At least once each year, a health insurer shall permit an  
16 individual who has been covered for at least 18 months under an  
17 individual health benefit plan to transfer, without medical  
18 underwriting, to any other individual health benefit plan offered  
19 by that same health insurer that provides equal or lesser benefits  
20 as determined by the insurer.

21 “Without medical underwriting” means that the health insurer  
22 shall not decline to offer coverage to, or deny enrollment of, the  
23 individual or impose any preexisting condition exclusion on the  
24 individual who transfers to another individual health benefit plan  
25 pursuant to this section.

26 (c) The insurer shall establish, for the purposes of subdivision  
27 (b), a ranking of the individual health benefit plans it offers to  
28 individual purchasers and post the ranking on its Internet Web site  
29 or make the ranking available upon request. The insurer shall  
30 update the ranking whenever a new benefit design for individual  
31 purchasers is approved.

32 (d) The insurer shall notify in writing all insureds of the right  
33 to transfer to another individual health benefit plan pursuant to  
34 this section, at a minimum, when the insurer changes the insured’s  
35 premium rate. Posting this information on the insurer’s Internet  
36 Web site shall not constitute notice for purposes of this subdivision.  
37 The notice shall adequately inform insureds of the transfer rights  
38 provided under this section including information on the process  
39 to obtain details about the individual health benefit plans available  
40 to that insured and advising that the insured may be unable to



1 return to his or her current individual health benefit plan if the  
2 insured transfers to another individual health benefit plan.

3 (e) The requirements of this section shall not apply to the  
4 following:

5 (1) A federally eligible defined individual, as defined in  
6 subdivision (e) of Section 10900, who purchases individual  
7 coverage pursuant to Section 10785.

8 (2) An individual offered conversion coverage pursuant to  
9 Sections 12672 and 12682.1.

10 (3) An individual enrolled in the Medi-Cal program pursuant  
11 to Chapter 7 (commencing with Section 14000) of Part 3 of  
12 Division 9 of the Welfare and Institutions Code.

13 (4) An individual enrolled in the Access for Infants and Mothers  
14 Program, pursuant to Part 6.3 (commencing with Section 12695).

15 (5) An individual enrolled in the Healthy Families Program  
16 pursuant to Part 6.2 (commencing with Section 12693).

17 (f) It is the intent of the Legislature that individuals shall have  
18 more choice in their health care coverage when health insurers  
19 guarantee the right of an individual to transfer to another product  
20 based on the insurer's own ranking system. The Legislature does  
21 not intend for the department to review or verify the insurer's  
22 ranking for actuarial or other purposes.

23 (g) (1) This section shall be inoperative on January 1, 2014.

24 (2) If Section 5000A of the Internal Revenue Code, as added  
25 by Section 1501 of PPACA, is repealed or amended to no longer  
26 apply to the individual market, as defined in Section ~~2794~~ 2791  
27 of the federal Public Health Service Act (42 U.S.C. Sec. ~~300gg-04~~;  
28 ~~300gg-91~~), this section shall become operative on the date of that  
29 repeal or amendment.

30 (3) For purposes of this subdivision, "PPACA" means the federal  
31 Patient Protection and Affordable Care Act (Public Law 111-148),  
32 as amended by the federal Health Care and Education  
33 Reconciliation Act of 2010 (Public Law 111-152), and any rules,  
34 regulations, or guidance issued pursuant to that law.

35 ~~SEC. 9.~~

36 *SEC. 15.* Section 10127.14 of the Insurance Code is amended  
37 to read:

38 10127.14. (a) The department and the Department of Managed  
39 Health Care shall compile information required by this section and  
40 Section 1363.06 of the Health and Safety Code into two

1 comparative benefit matrices. The first matrix shall compare benefit  
2 packages offered pursuant to Section 1373.62 of the Health and  
3 Safety Code and Section 10127.15. The second matrix shall  
4 compare benefit packages offered pursuant to Sections 1366.35,  
5 1373.6, and 1399.804 of the Health and Safety Code and Sections  
6 10785, 10901.2, and 12682.1.

7 (b) The comparative benefit matrix shall include:

8 (1) Benefit information submitted by health care service plans  
9 pursuant to Section 1363.06 of the Health and Safety Code and by  
10 health insurers pursuant to subdivision (d).

11 (2) The following statements in at least 12-point type at the top  
12 of the matrix:

13 (A) "This benefit summary is intended to help you compare  
14 coverage and benefits and is a summary only. For a more detailed  
15 description of coverage, benefits, and limitations, please contact  
16 the health care service plan or health insurer."

17 (B) "The comparative benefit summary is updated annually, or  
18 more often if necessary to be accurate."

19 (C) "The most current version of this comparative benefit  
20 summary is available on (address of the plan's or insurer's site)."

21 This subparagraph applies only to those health insurers that  
22 maintain an Internet Web site.

23 (3) The telephone number or numbers that may be used by an  
24 applicant to contact either the department or the Department of  
25 Managed Health Care, as appropriate, for further assistance.

26 (c) The department and the Department of Managed Health  
27 Care shall jointly prepare two standardized templates for use by  
28 health care service plans and health insurers in submitting the  
29 information required pursuant to subdivision (d) of Section 1363.06  
30 and subdivision (d). The templates shall be exempt from the  
31 provisions of Chapter 3.5 (commencing with Section 11340) of  
32 Part 1 of Division 3 of Title 2 of the Government Code.

33 (d) Health insurers shall submit the following to the department  
34 by January 31, 2003, and annually thereafter:

35 (1) A summary explanation of the following for each product  
36 described in subdivision (a):

37 (A) Eligibility requirements.

38 (B) The full premium cost of each benefit package in the service  
39 area in which the individual and eligible dependents work or reside.

40 (C) When and under what circumstances benefits cease.

1 (D) The terms under which coverage may be renewed.

2 (E) Other coverage that may be available if benefits under the  
3 described benefit package cease.

4 (F) The circumstances under which choice in the selection of  
5 physicians and providers is permitted.

6 (G) Lifetime and annual maximums.

7 (H) Deductibles.

8 (2) A summary explanation of the following coverages, together  
9 with the corresponding copayments and limitations, for each  
10 product described in subdivision (a):

11 (A) Professional services.

12 (B) Outpatient services.

13 (C) Hospitalization services.

14 (D) Emergency health coverage.

15 (E) Ambulance services.

16 (F) Prescription drug coverage.

17 (G) Durable medical equipment.

18 (H) Mental health services.

19 (I) Residential treatment.

20 (J) Chemical dependency services.

21 (K) Home health services.

22 (L) Custodial care and skilled nursing facilities.

23 (3) The telephone number or numbers that may be used by an  
24 applicant to access a health insurer customer service representative  
25 and to request additional information about the insurance policy.

26 (4) Any other information specified by the department in the  
27 template.

28 (e) Each health insurer shall provide the department with updates  
29 to the information required by subdivision (d) at least annually, or  
30 more often if necessary to maintain the accuracy of the information.

31 (f) The department and the Department of Managed Health Care  
32 shall make the comparative benefit matrices available on their  
33 respective Internet Web sites and to the health care service plans  
34 and health insurers for dissemination as required by Section 1373.6  
35 of the Health and Safety Code and Section 12682.1, after  
36 confirming the accuracy of the description of the matrices with  
37 the health insurers and health care service plans.

38 (g) As used in this section, “benefit matrix” shall have the same  
39 meaning as benefit summary.

(h) This section shall not apply to accident-only, specified disease, hospital indemnity, CHAMPUS supplement, long-term care, Medicare supplement, dental-only, or vision-only insurance policies.

(i) (1) This section shall be inoperative on January 1, 2014.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section ~~2794~~ 2791 of the federal Public Health Service Act (42 U.S.C. Sec. ~~300gg-04~~), ~~300g-91~~), this section shall become operative on the date of that repeal or amendment.

(3) For purposes of this subdivision, “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

~~SEC. 10.~~

*SEC. 16.* Section 10127.18 of the Insurance Code is amended to read:

10127.18. (a) On and after January 1, 2005, a health insurer issuing individual policies of health insurance that ceases to offer individual coverage in this state shall offer coverage to the policyholders who had been covered by those policies at the time of withdrawal under the same terms and conditions as provided in paragraph (3) of subdivision (a), paragraphs (2) to (4), inclusive, of subdivision (b), subdivisions (c) to (e), inclusive, and subdivision (h) of Section 12682.1.

(b) The department may adopt regulations to implement this section.

(c) This section shall not apply when a plan participating in Medi-Cal, Healthy Families, Access for Infants and Mothers, or any other contract between the plan and a government entity no longer contracts with the government entity to provide health coverage in the state, or a specified area of the state, nor shall this section apply when a plan ceases entirely to market, offer, and issue any and all forms of coverage in any part of this state after the effective date of this section.

(d) (1) This section shall be inoperative on January 1, 2014.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer

1 apply to the individual market, as defined in Section 2794.2791  
2 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-04);  
3 300gg-91), this section shall become operative on the date of that  
4 repeal or amendment.

5 (3) For purposes of this subdivision, “PPACA” means the federal  
6 Patient Protection and Affordable Care Act (Public Law 111-148),  
7 as amended by the federal Health Care and Education  
8 Reconciliation Act of 2010 (Public Law 111-152), and any rules,  
9 regulations, or guidance issued pursuant to that law.

10 ~~SEC. 11. Section 10902.4 of the Insurance Code is repealed.~~

11 *SEC. 17. Section 10785 of the Insurance Code is amended to*  
12 *read:*

13 10785. (a) A disability insurer that covers hospital, medical,  
14 or surgical expenses under an individual health benefit plan as  
15 defined in subdivision (a) of Section 10198.6 may not, with respect  
16 to a federally eligible defined individual desiring to enroll in  
17 individual health insurance coverage, decline to offer coverage to,  
18 or deny enrollment of, the individual or impose any preexisting  
19 condition exclusion with respect to the coverage.

20 (b) For purposes of this section, “federally eligible defined  
21 individual” means an individual who, as of the date on which the  
22 individual seeks coverage under this section, meets all of the  
23 following conditions:

24 (1) Has had 18 or more months of creditable coverage, and  
25 whose most recent prior creditable coverage was under a group  
26 health plan, a federal governmental plan maintained for federal  
27 employees, or a governmental plan or church plan as defined in  
28 the federal Employee Retirement Income Security Act of 1974  
29 (29 U.S.C. Sec. 1002).

30 (2) Is not eligible for coverage under a group health plan,  
31 Medicare, or Medi-Cal, and does not have other health insurance  
32 coverage.

33 (3) Was not terminated from his or her most recent creditable  
34 coverage due to nonpayment of premiums or fraud.

35 (4) If offered continuation coverage under COBRA or  
36 Cal-COBRA, has elected and exhausted that coverage.

37 (c) Every disability insurer that covers hospital, medical, or  
38 surgical expenses shall comply with applicable federal statutes  
39 and regulations regarding the provision of coverage to federally

1 eligible defined individuals, including any relevant application  
2 periods.

3 (d) A disability insurer shall offer the following health benefit  
4 plans under this section that are designed for, made generally  
5 available to, are actively marketed to, and enroll, individuals:

6 (1) either the two most popular products as defined in Section  
7 300gg-41(c)(2) of Title 42 of the United States Code and Section  
8 148.120(c)(2) of Title 45 of the Code of Federal Regulations or  
9 (2) the two most representative products as defined in Section  
10 300gg-41(c)(3) of the United States Code and Section  
11 148.120(c)(3) of Title 45 of the Code of Federal Regulations, as  
12 determined by the insurer in compliance with federal law. An  
13 insurer that offers only one health benefit plan to individuals,  
14 excluding health benefit plans offered to Medi-Cal or Medicare  
15 beneficiaries, shall be deemed to be in compliance with this chapter  
16 if it offers that health benefit plan contract to federally eligible  
17 defined individuals in a manner consistent with this chapter.

18 (e) (1) In the case of a disability insurer that offers health benefit  
19 plans in the individual market through a network plan, the insurer  
20 may do both of the following:

21 (A) Limit the individuals who may be enrolled under that  
22 coverage to those who live, reside, or work within the service area  
23 for the network plan.

24 (B) Within the service area covered by the health benefit plan,  
25 deny coverage to individuals if the insurer has demonstrated to the  
26 commissioner that the insured will not have the capacity to deliver  
27 services adequately to additional individual insureds because of  
28 its obligations to existing group policyholders, group  
29 contractholders and insureds, and individual insureds, and that the  
30 insurer is applying this paragraph uniformly to individuals without  
31 regard to any health status-related factor of the individuals and  
32 without regard to whether the individuals are federally eligible  
33 defined individuals.

34 (2) A disability insurer, upon denying health insurance coverage  
35 in any service area in accordance with subparagraph (B) of  
36 paragraph (1), may not offer health benefit plans through a network  
37 in the individual market within that service area for a period of  
38 180 days after the coverage is denied.

39 (f) (1) A disability insurer may deny health insurance coverage  
40 in the individual market to a federally eligible defined individual

1 if the insurer has demonstrated to the commissioner both of the  
2 following:

3 (A) The insurer does not have the financial reserves necessary  
4 to underwrite additional coverage.

5 (B) The insurer is applying this subdivision uniformly to all  
6 individuals in the individual market and without regard to any  
7 health status-related factor of the individuals and without regard  
8 to whether the individuals are federally eligible defined individuals.

9 (2) A disability insurer, upon denying individual health  
10 insurance coverage in any service area in accordance with  
11 paragraph (1), may not offer that coverage in the individual market  
12 within that service area for a period of 180 days after the date the  
13 coverage is denied or until the insurer has demonstrated to the  
14 commissioner that the insurer has sufficient financial reserves to  
15 underwrite additional coverage, whichever is later.

16 (g) The requirement pursuant to federal law to furnish a  
17 certificate of creditable coverage shall apply to health benefits  
18 plans offered by a disability insurer in the individual market in the  
19 same manner as it applies to an insurer in connection with a group  
20 health benefit plan policy or group health benefit plan contract.

21 (h) A disability insurer shall compensate a life agent, property  
22 broker-agent, or casualty broker-agent whose activities result in  
23 the enrollment of federally eligible defined individuals in the same  
24 manner and consistent with the renewal commission amounts as  
25 the insurer compensates life agents, property broker-agents, or  
26 casualty broker-agents for other enrollees who are not federally  
27 eligible defined individuals and who are purchasing the same  
28 individual health benefit plan.

29 (i) Every disability insurer shall disclose as part of its COBRA  
30 or Cal-COBRA disclosure and enrollment documents, an  
31 explanation of the availability of guaranteed access to coverage  
32 under the Health Insurance Portability and Accountability Act of  
33 1996, including the necessity to enroll in and exhaust COBRA or  
34 Cal-COBRA benefits in order to become a federally eligible  
35 defined individual.

36 (j) No disability insurer may request documentation as to  
37 whether or not a person is a federally eligible defined individual  
38 other than is permitted under applicable federal law or regulations.

(k) This section shall not apply to coverage defined as excepted benefits pursuant to Section 300gg(c) of Title 42 of the United States Code.

(l) This section shall apply to policies or contracts offered, delivered, amended, or renewed on or after January 1, 2001.

(m) (1) *On and after January 1, 2014, and except as provided in paragraph (2), this section shall apply only to individual grandfathered health plans previously issued pursuant to this section to federally eligible defined individuals.*

(2) *If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Section 300gg-91), paragraph (1) shall become inoperative on the date of that repeal or amendment and this section shall apply to health benefit plans issued, amended, or renewed on or after that date.*

(3) *For purposes of this subdivision, the following definitions apply:*

(A) *“Grandfathered health plan” has the same meaning as that term is defined in Section 1251 of PPACA.*

(B) *“PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issues pursuant to that law.*

*SEC. 18. Section 10901.3 of the Insurance Code is amended to read:*

10901.3. (a) (1) After the federally eligible defined individual submits a completed application form for a health benefit plan, the carrier shall, within 30 days, notify the individual of the individual’s actual premium charges for that health benefit plan design. In no case shall the premium charged for any health benefit plan identified in subdivision (d) of Section 10785 exceed the following amounts:

(A) For health benefit plans that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64,



1 inclusive, the premium shall not exceed the average premium paid  
2 by a subscriber of the Major Risk Medical Insurance Program who  
3 is 59 years of age and resides in the same geographic area as the  
4 federally eligible defined individual.

5 (B) For health benefit plans identified in subdivision (d) of  
6 Section 10785 that do not offer services through a preferred  
7 provider arrangement, 170 percent of the standard premium charged  
8 to an individual who is of the same age and resides in the same  
9 geographic area as the federally eligible defined individual.  
10 However, for federally qualified individuals who are between the  
11 ages of 60 and 64, inclusive, the premium shall not exceed 170  
12 percent of the standard premium charged to an individual who is  
13 59 years of age and resides in the same geographic area as the  
14 federally eligible defined individual. The individual shall have 30  
15 days in which to exercise the right to buy coverage at the quoted  
16 premium rates.

17 (2) A carrier may adjust the premium based on family size, not  
18 to exceed the following amounts:

19 (A) For health benefit plans that offer services through a  
20 preferred provider arrangement, the average of the Major Risk  
21 Medical Insurance Program rate for families of the same size that  
22 reside in the same geographic area as the federally eligible defined  
23 individual.

24 (B) For health benefit plans identified in subdivision (d) of  
25 Section 10785 that do not offer services through a preferred  
26 provider arrangement, 170 percent of the standard premium charged  
27 to a family that is of the same size and resides in the same  
28 geographic area as the federally eligible defined individual.

29 (b) When a federally eligible defined individual submits a  
30 premium payment, based on the quoted premium charges, and that  
31 payment is delivered or postmarked, whichever occurs earlier,  
32 within the first 15 days of the month, coverage shall begin no later  
33 than the first day of the following month. When that payment is  
34 neither delivered or postmarked until after the 15th day of a month,  
35 coverage shall become effective no later than the first day of the  
36 second month following delivery or postmark of the payment.

37 (c) During the first 30 days after the effective date of the health  
38 benefit plan, the individual shall have the option of changing  
39 coverage to a different health benefit plan design offered by the  
40 same carrier. If the individual notified the plan of the change within

1 the first 15 days of a month, coverage under the new health benefit  
2 plan shall become effective no later than the first day of the  
3 following month. If an enrolled individual notified the carrier of  
4 the change after the 15th day of a month, coverage under the health  
5 benefit plan shall become effective no later than the first day of  
6 the second month following notification.

7 *(d) (1) On and after January 1, 2014, and except as provided*  
8 *in paragraph (2), this section shall apply only to individual*  
9 *grandfathered health plans previously issued pursuant to this*  
10 *section to federally eligible defined individuals.*

11 *(2) If Section 5000A of the Internal Revenue Code, as added by*  
12 *Section 1501 of PPACA, is repealed or amended to no longer apply*  
13 *to the individual market, as defined in Section 2791 of the federal*  
14 *Public Health Service Act (42 U.S.C. Section 300gg-91), paragraph*  
15 *(1) shall become inoperative on the date of that repeal or*  
16 *amendment and this section shall apply to health benefit plans*  
17 *issued, amended, or renewed on or after that date.*

18 *(3) For purposes of this subdivision, the following definitions*  
19 *apply:*

20 *(A) "Grandfathered health plan" has the same meaning as that*  
21 *term is defined in Section 1251 of PPACA.*

22 *(B) "PPACA" means the federal Patient Protection and*  
23 *Affordable Care Act (Public Law 111-148), as amended by the*  
24 *federal Health Care and Education Reconciliation Act of 2010*  
25 *(Public Law 111-152), and any rules, regulations, or guidance*  
26 *issues pursuant to that law.*

27 *SEC. 19. Section 10901.8 of the Insurance Code is amended*  
28 *to read:*

29 10901.8. All health benefit plans offered to a federally eligible  
30 defined individual shall be renewable with respect to the individual  
31 and dependents at the option of the enrolled individual except in  
32 cases of:

33 (a) Nonpayment of the required premiums.

34 (b) Fraud or misrepresentation by the enrolled individual.

35 (c) The carrier ceases to provide or arrange for the provision of  
36 health care services for individual health benefit plan contracts in  
37 this state, provided, however, that the following conditions are  
38 satisfied:

1 (1) Notice of the decision to cease new or existing individual  
2 health benefit plans in this state is provided to the commissioner  
3 and to the contractholder.

4 (2) Individual health benefit plan contracts subject to this chapter  
5 shall not be canceled for 180 days after the date of the notice  
6 required under paragraph (1) and for that business of a carrier that  
7 remains in force, any carrier that ceases to offer for sale new  
8 individual health benefit plan contracts shall continue to be  
9 governed by this article with respect to business conducted under  
10 this chapter.

11 (3) A carrier that ceases to write new individual business in this  
12 state after the effective date of this chapter shall be prohibited from  
13 offering for sale new individual health benefit plan contracts in  
14 this state for a period of three years from the date of the notice to  
15 the commissioner.

16 (d) When a carrier withdraws a health benefit plan design from  
17 the individual market, provided that a carrier makes available to  
18 eligible individuals all health plan benefit designs that it makes  
19 available to new individual business, and provided that premium  
20 for the new health benefit plan complies with the renewal increase  
21 requirements set forth in Section 10901.9.

22 *(e) (1) On and after January 1, 2014, and except as provided*  
23 *in paragraph (2), this section shall apply only to individual*  
24 *grandfathered health plans previously issued pursuant to this*  
25 *section to federally eligible defined individuals.*

26 *(2) If Section 5000A of the Internal Revenue Code, as added by*  
27 *Section 1501 of PPACA, is repealed or amended to no longer apply*  
28 *to the individual market, as defined in Section 2791 of the federal*  
29 *Public Health Service Act (42 U.S.C. Section 300gg-91), paragraph*  
30 *(1) shall become inoperative on the date of that repeal or*  
31 *amendment and this section shall apply to health benefit plans*  
32 *issued, amended, or renewed on or after that date.*

33 *(3) For purposes of this subdivision, the following definitions*  
34 *apply:*

35 *(A) "Grandfathered health plan" has the same meaning as that*  
36 *term is defined in Section 1251 of PPACA.*

37 *(B) "PPACA" means the federal Patient Protection and*  
38 *Affordable Care Act (Public Law 111-148), as amended by the*  
39 *federal Health Care and Education Reconciliation Act of 2010*

1 (*Public Law 111-152*), and any rules, regulations, or guidance  
2 issues pursuant to that law.

3 SEC. 20. Section 10901.9 of the Insurance Code is amended  
4 to read:

5 10901.9. Commencing January 1, 2001, premiums for health  
6 benefit plans offered, delivered, amended, or renewed by carriers  
7 shall be subject to the following requirements:

8 (a) The premium for new business for a federally eligible defined  
9 individual shall not exceed the following amounts:

10 (1) For health benefit plans identified in subdivision (d) of  
11 Section 10785 that offer services through a preferred provider  
12 arrangement, the average premium paid by a subscriber of the  
13 Major Risk Medical Insurance Program who is of the same age  
14 and resides in the same geographic area as the federally eligible  
15 defined individual. However, for federally qualified individuals  
16 who are between the ages of 60 to 64, inclusive, the premium shall  
17 not exceed the average premium paid by a subscriber of the Major  
18 Risk Medical Insurance Program who is 59 years of age and resides  
19 in the same geographic area as the federally eligible defined  
20 individual.

21 (2) For health benefit plans identified in subdivision (d) of  
22 Section 10785 that do not offer services through a preferred  
23 provider arrangement, 170 percent of the standard premium charged  
24 to an individual who is of the same age and resides in the same  
25 geographic area as the federally eligible defined individual.  
26 However, for federally qualified individuals who are between the  
27 ages of 60 to 64, inclusive, the premium shall not exceed 170  
28 percent of the standard premium charged to an individual who is  
29 59 years of age and resides in the same geographic area as the  
30 federally eligible defined individual.

31 (b) The premium for in force business for a federally eligible  
32 defined individual shall not exceed the following amounts:

33 (1) For health benefit plans identified in subdivision (d) of  
34 Section 10785 that offer services through a preferred provider  
35 arrangement, the average premium paid by a subscriber of the  
36 Major Risk Medical Insurance Program who is of the same age  
37 and resides in the same geographic area as the federally eligible  
38 defined individual. However, for federally qualified individuals  
39 who are between the ages of 60 and 64, inclusive, the premium  
40 shall not exceed the average premium paid by a subscriber of the

1 Major Risk Medical Insurance Program who is 59 years of age  
2 and resides in the same geographic area as the federally eligible  
3 defined individual.

4 (2) For health benefit plans identified in subdivision (d) of  
5 Section 10785 that do not offer services through a preferred  
6 provider arrangement, 170 percent of the standard premium charged  
7 to an individual who is of the same age and resides in the same  
8 geographic area as the federally eligible defined individual.  
9 However, for federally qualified individuals who are between the  
10 ages of 60 and 64, inclusive, the premium shall not exceed 170  
11 percent of the standard premium charged to an individual who is  
12 59 years of age and resides in the same geographic area as the  
13 federally eligible defined individual. The premium effective on  
14 January 1, 2001, shall apply to in force business at the earlier of  
15 either the time of renewal or July 1, 2001.

16 (c) The premium applied to a federally eligible defined  
17 individual may not increase by more than the following amounts:

18 (1) For health benefit plans identified in subdivision (d) of  
19 Section 10785 that offer services through a preferred provider  
20 arrangement, the average increase in the premiums charged to a  
21 subscriber of the Major Risk Medical Insurance Program who is  
22 of the same age and resides in the same geographic area as the  
23 federally eligible defined individual.

24 (2) For health benefit plans identified in subdivision (d) of  
25 Section 10785 that do not offer services through a preferred  
26 provider arrangement, the increase in premiums charged to a  
27 nonfederally qualified individual who is of the same age and resides  
28 in the same geographic area as the federally defined eligible  
29 individual. The premium for an eligible individual may not be  
30 modified more frequently than every 12 months.

31 ~~(2)~~

32 (3) For a contract that a carrier has discontinued offering, the  
33 premium applied to the first rating period of the new contract that  
34 the federally eligible defined individual elects to purchase shall  
35 be no greater than the premium applied in the prior rating period  
36 to the discontinued contract.

37 (m) (1) *On and after January 1, 2014, and except as provided*  
38 *in paragraph (2), this section shall apply only to individual*  
39 *grandfathered health plans previously issued pursuant to this*  
40 *section to federally eligible defined individuals.*

(2) *If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Section 300gg-91), paragraph (1) shall become inoperative on the date of that repeal or amendment and this section shall apply to health benefit plans issued, amended, or renewed or amended on or after that date.*

(3) *For purposes of this subdivision, the following definitions apply:*

(A) *“Grandfathered health plan” has the same meaning as that term is defined in Section 1251 of PPACA.*

(B) *“PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issues pursuant to that law.*

SEC. 21. *Section 10902.3 of the Insurance Code is amended to read:*

10902.3. (a) At least 20 business days prior to renewing or amending a health benefit plan contract subject to this chapter, or at least 20 business days prior to the initial offering of a health benefit plan subject to this chapter, a carrier shall file a statement with the commissioner in the same manner as required for small employers as outlined in Section 10717. The statement shall include a statement certifying that the carrier is in compliance with subdivision (a) of Section 10901.3 and with Section 10901.9. Any action by the commissioner, as permitted under Section 10717, to disapprove, suspend, or postpone the plan’s use of a carrier’s health benefit plan design shall be in writing, specifying the reasons the health benefit plan does not comply with the requirements of this chapter.

(b) Prior to making any changes in the premium, the carrier shall file an amendment in the same manner as required for small employers as outlined in Section 10717, and shall include a statement certifying the carrier is in compliance with subdivision (a) of Section 10901.3 and with Section 10901.9. All other changes to a health benefit plan previously filed with the commissioner pursuant to subdivision (a) shall be filed as an amendment in the same manner as required for small employers as outlined in Section 10717.

1 (c) (1) On and after January 1, 2014, and except as provided  
2 in paragraph (2), this section shall apply only to individual  
3 grandfathered health plans previously issued pursuant to this  
4 section to federally eligible defined individuals.

5 (2) If Section 5000A of the Internal Revenue Code, as added by  
6 Section 1501 of PPACA, is repealed or amended to no longer apply  
7 to the individual market, as defined in Section 2791 of the federal  
8 Public Health Service Act (42 U.S.C. Section 300gg-91), paragraph  
9 (1) shall become inoperative on the date of that repeal or  
10 amendment and this section shall apply to health benefit plans  
11 issued, amended, or renewed on or after that date.

12 (3) For purposes of this subdivision, the following definitions  
13 apply:

14 (A) "Grandfathered health plan" has the same meaning as that  
15 term is defined in Section 1251 of PPACA.

16 (B) "PPACA" means the federal Patient Protection and  
17 Affordable Care Act (Public Law 111-148), as amended by the  
18 federal Health Care and Education Reconciliation Act of 2010  
19 (Public Law 111-152), and any rules, regulations, or guidance  
20 issues pursuant to that law.

21 ~~SEC. 12.~~

22 ~~SEC. 22.~~ Section 10902.6 of the Insurance Code is repealed.

23 ~~SEC. 13.~~ Section 10902.6 is added to the Insurance Code, to  
24 read:

25 ~~10902.6. (a) On and after January 1, 2014, this chapter and~~  
26 ~~Sections 10785 and 12682.1 shall apply only to grandfathered~~  
27 ~~individual health insurance policies previously issued to federally~~  
28 ~~eligible defined individuals.~~

29 ~~(b) If Section 5000A of the Internal Revenue Code, as added~~  
30 ~~by Section 1501 of PPACA, is repealed or amended to no longer~~  
31 ~~apply to the individual market, as defined in Section 2791 of the~~  
32 ~~federal Public Health Service Act (42 U.S.C. Sec. 300gg-04), this~~  
33 ~~section shall become inoperative and shall be repealed on January~~  
34 ~~1 following the date that it becomes inoperative.~~

35 ~~(c) For purposes of this section, the following definitions apply:~~

36 ~~(1) "Grandfathered health insurance policy" has the same~~  
37 ~~meaning as "grandfathered health plan" in Section 1251 of PPACA.~~

38 ~~(2) "PPACA" means the federal Patient Protection and~~  
39 ~~Affordable Care Act (Public Law 111-148), as amended by the~~  
40 ~~federal Health Care and Education Reconciliation Act of 2010~~

1 ~~(Public Law 111-152), and any rules, regulations, or guidance~~  
2 ~~issued pursuant to that law.~~

3 ~~SEC. 14.~~

4 *SEC. 23.* Section 12672 of the Insurance Code is amended to  
5 read:

6 12672. (a) Any group policy issued, amended, or renewed in  
7 this state on or after January 1, 1983, which provides insurance  
8 for employees or members on an expense-incurred or service basis,  
9 other than for a specific disease or for accidental injuries only,  
10 shall contain a provision that an employee or member whose  
11 coverage under the group policy has been terminated for any reason  
12 except as provided in this part, shall be entitled to have a converted  
13 policy issued to him or her by the insurer under whose group policy  
14 he or she was covered, without evidence of insurability, subject  
15 to the terms and conditions of this part.

16 (b) (1) This section shall be inoperative on January 1, 2014.

17 (2) If Section 5000A of the Internal Revenue Code, as added  
18 by Section 1501 of PPACA, is repealed or amended to no longer  
19 apply to the individual market, as defined in Section ~~2794~~ 2791  
20 of the federal Public Health Service Act (42 U.S.C. Sec. ~~300gg-04~~  
21 *300gg-91*), this section shall become operative on the date of that  
22 repeal or amendment.

23 (3) For purposes of this subdivision, “PPACA” means the federal  
24 Patient Protection and Affordable Care Act (Public Law 111-148),  
25 as amended by the federal Health Care and Education  
26 Reconciliation Act of 2010 (Public Law 111-152), and any rules,  
27 regulations, or guidance issued pursuant to that law.

28 *SEC. 24.* *Section 12682.1 of the Insurance Code is amended*  
29 *to read:*

30 12682.1. This section does not apply to a policy that primarily  
31 or solely supplements Medicare. The commissioner may adopt  
32 rules consistent with federal law to govern the discontinuance and  
33 replacement of plan policies that primarily or solely supplement  
34 Medicare.

35 (a) (1) Every group policy entered into, amended, or renewed  
36 on or after September 1, 2003, that provides hospital, medical, or  
37 surgical expense benefits for employees or members shall provide  
38 that an employee or member whose coverage under the group  
39 policy has been terminated by the employer shall be entitled to



1 convert to nongroup membership, without evidence of insurability,  
2 subject to the terms and conditions of this section.

3 (2) If the health insurer provides coverage under an individual  
4 health insurance policy, other than conversion coverage under this  
5 part, it shall offer one of the two health insurance policies that the  
6 insurer is required to offer to a federally eligible defined individual  
7 pursuant to Section 10785. The health insurer shall provide this  
8 coverage at the same rate established under Section 10901.3 for a  
9 federally eligible defined individual.

10 (3) If the health insurer does not provide coverage under an  
11 individual health insurance policy, it shall offer a health benefit  
12 plan contract that is the same as a health benefit contract offered  
13 to a federally eligible defined individual pursuant to Section  
14 1366.35. The health insurer shall offer the most popular preferred  
15 provider organization plan that has the greatest number of enrolled  
16 individuals for its type of plan as of January 1 of the prior year, as  
17 reported by plans by January 31, 2003, and annually thereafter,  
18 that provide coverage under an individual health care service plan  
19 contract to the department or the Department of Managed Health  
20 Care. A health insurer subject to this paragraph plan shall provide  
21 this coverage with the same cost-sharing terms and at the same  
22 premium as a health care service plan providing coverage to that  
23 individual under an individual health care service plan contract  
24 pursuant to Section 1399.805. The health insurer shall file the  
25 health benefit plan contract it will offer, including the premium it  
26 will charge and the cost-sharing terms of the contract, with the  
27 Department of Insurance.

28 (b) A conversion policy shall not be required to be made  
29 available to an employee or insured if termination of his or her  
30 coverage under the group policy occurred for any of the following  
31 reasons:

32 (1) The group policy terminated or an employer's participation  
33 terminated and the insurance is replaced by similar coverage under  
34 another group policy within 15 days of the date of termination of  
35 the group coverage or the employer's participation.

36 (2) The employee or insured failed to pay amounts due the health  
37 insurer.

38 (3) The employee or insured was terminated by the health insurer  
39 from the policy for good cause.

1 (4) The employee or insured knowingly furnished incorrect  
2 information or otherwise improperly obtained the benefits of the  
3 policy.

4 (5) The employer's hospital, medical, or surgical expense benefit  
5 program is self-insured.

6 (c) A conversion policy is not required to be issued to any person  
7 if any of the following facts are present:

8 (1) The person is covered by or is eligible for benefits under  
9 Title XVIII of the United States Social Security Act.

10 (2) The person is covered by or is eligible for hospital, medical,  
11 or surgical benefits under any arrangement of coverage for  
12 individuals in a group, whether insured or self-insured.

13 (3) The person is covered for similar benefits by an individual  
14 policy or contract.

15 (4) The person has not been continuously covered during the  
16 three-month period immediately preceding that person's  
17 termination of coverage.

18 (d) Benefits of a conversion policy shall meet the requirements  
19 for benefits under this chapter.

20 (e) Unless waived in writing by the insurer, written application  
21 and first premium payment for the conversion policy shall be made  
22 not later than 63 days after termination from the group. A  
23 conversion policy shall be issued by the insurer which shall be  
24 effective on the day following the termination of coverage under  
25 the group contract if the written application and the first premium  
26 payment for the conversion contract are made to the insurer not  
27 later than 63 days after the termination of coverage, unless these  
28 requirements are waived in writing by the insurer.

29 (f) The conversion policy shall cover the employee or insured  
30 and his or her dependents who were covered under the group policy  
31 on the date of their termination from the group.

32 (g) A notification of the availability of the conversion coverage  
33 shall be included in each evidence of coverage or other legally  
34 required document explaining coverage. However, it shall be the  
35 sole responsibility of the employer to notify its employees of the  
36 availability, terms, and conditions of the conversion coverage  
37 which responsibility shall be satisfied by notification within 15  
38 days of termination of group coverage. Group coverage shall not  
39 be deemed terminated until the expiration of any continuation of  
40 the group coverage. For purposes of this subdivision, the employer

1 shall not be deemed the agent of the insurer for purposes of  
2 notification of the availability, terms, and conditions of conversion  
3 coverage.

4 (h) As used in this section, “hospital, medical, or surgical  
5 benefits under state or federal law” do not include benefits under  
6 Chapter 7 (commencing with Section 14000) or Chapter 8  
7 (commencing with Section 14200) of Part 3 of Division 9 of the  
8 Welfare and Institutions Code, or Title XIX of the United States  
9 Social Security Act.

10 ~~(i) This section shall become operative on September 1, 2003.~~

11 (i) *(1) On and after January 1, 2014, and except as provided*  
12 *in paragraph (2), this section shall not apply to any health*  
13 *insurance policies.*

14 *(2) If Section 5000A of the Internal Revenue Code, as added by*  
15 *Section 1501 of PPACA, is repealed or amended to no longer apply*  
16 *to the individual market, as defined in Section 2791 of the federal*  
17 *Public Health Service Act (42 U.S.C. Section 300gg-91), paragraph*  
18 *(1) shall become inoperative on the date of that repeal or*  
19 *amendment and this section shall apply to health insurance policies*  
20 *issued, renewed, or amended on or after that date.*

21 *(3) For purposes of this subdivision, “PPACA” means the*  
22 *federal Patient Protection and Affordable Care Act (Public Law*  
23 *111-148), as amended by the federal Health Care and Education*  
24 *Reconciliation Act of 2010 (Public Law 111-152), and any rules,*  
25 *regulations, or guidance issues pursuant to that law.*

26 SEC. 25. *Section 12682.2 is added to the Insurance Code, to*  
27 *read:*

28 12682.2. (a) (1) *At least 60 days prior to the policy renewal*  
29 *date, an insurer that does not otherwise issue individual health*  
30 *insurance policies shall issue the notice described in paragraph*  
31 *(2) to any policyholder of an individual health insurance policy*  
32 *issued pursuant to Section 12682.1 that is not a grandfathered*  
33 *health plan.*

34 (2) *The notice shall be in at least 12-point type and shall include*  
35 *all of the following information:*

36 (A) *Notice that, as of the renewal date, the individual policy*  
37 *will not be renewed.*

38 (B) *The availability of individual health coverage through*  
39 *Covered California, including at least all of the following:*

1     (i) That, beginning on January 1, 2014, individuals seeking  
2     coverage may not be denied coverage based on health status.

3     (ii) That the premium rates for coverage offered by a health  
4     care service plan or a health insurer cannot be based on an  
5     individual's health status.

6     (iii) That individuals obtaining coverage through Covered  
7     California may, depending upon income, be eligible for premium  
8     subsidies and cost-sharing subsidies.

9     (iv) That individuals seeking coverage must obtain this coverage  
10    during an open or special enrollment period, and describe the  
11    open and special enrollment periods that may apply.

12    (b) (1) At least 60 days prior to the policy renewal date, an  
13    insurer that issues individual health insurance policies shall issue  
14    the notice described in paragraph (2) to a policyholder of an  
15    individual health insurance policy issued pursuant to Section 10785  
16    or 12682.1 that is not a grandfathered health plan.

17    (2) The notice shall be in at least 12-point type and shall include  
18    all of the following:

19    (A) Notice that, as of the renewal date, the individual policy  
20    shall not be renewed.

21    (B) Information regarding the individual health insurance policy  
22    that the insurer will issue as of January 1, 2014, which the insurer  
23    has reasonably concluded is the most comparable to the  
24    individual's current policy. The notice shall include information  
25    on premiums for the possible replacement policy and instructions  
26    that the individual can continue their coverage by paying the  
27    premium stated by the due date.

28    (C) Notice of the availability of other individual health coverage  
29    through Covered California, including at least all of the following:

30    (i) That, beginning on January 1, 2014, individuals seeking  
31    coverage may not be denied coverage based on health status.

32    (ii) That the premium rates for coverage offered by a health  
33    care service plan or a health insurer cannot be based on an  
34    individual's health status.

35    (iii) That individuals obtaining coverage through Covered  
36    California may, depending upon income, be eligible for premium  
37    subsidies and cost-sharing subsidies.

38    (iv) That individuals seeking coverage must obtain this coverage  
39    during an open or special enrollment period, and describe the  
40    open and special enrollment periods that may apply.

1 (c) No later than September 1, 2013, the commissioner, in  
2 consultation with the Department of Managed Health Care, shall  
3 adopt uniform model notices that health plans shall use to comply  
4 with subdivisions (a) and (b). Use of the model notices shall not  
5 require prior approval by the department. The model notices  
6 adopted for purposes of this section shall not be subject to the  
7 Administrative Procedure Act (Chapter 3.5 (commencing with  
8 Section 11340) of Part 1 of Division 3 of Title 2 of the Government  
9 Code).

10 (d) For purposes of this section, the following definitions shall  
11 apply:

12 (1) "Covered California" means the California Health Benefit  
13 Exchange established pursuant to Section 100500 of the  
14 Government Code.

15 (2) "Grandfathered health plan" has the same meaning as that  
16 term is defined in Section 1251 of PPACA.

17 (3) "PPACA" means the federal Patient Protection and  
18 Affordable Care Act (Public Law 111-148), as amended by the  
19 federal Health Care and Education Reconciliation Act of 2010  
20 (Public Law 111-152), and any rules, regulations, or guidance  
21 issued pursuant to that law.

22 SEC. 26. No reimbursement is required by this act pursuant  
23 to Section 6 of Article XIII B of the California Constitution because  
24 the only costs that may be incurred by a local agency or school  
25 district will be incurred because this act creates a new crime or  
26 infraction, eliminates a crime or infraction, or changes the penalty  
27 for a crime or infraction, within the meaning of Section 17556 of  
28 the Government Code, or changes the definition of a crime within  
29 the meaning of Section 6 of Article XIII B of the California  
30 Constitution.

31 SEC. 27. This act is an urgency statute necessary for the  
32 immediate preservation of the public peace, health, or safety within  
33 the meaning of Article IV of the Constitution and shall go into  
34 immediate effect. The facts constituting the necessity are:

35 In order for the public to be informed in a timely manner of  
36 critical changes to health care coverage, it is necessary that this  
37 bill take effect immediately.